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St. Bartholomew's Hospital Journal,
JANUARY 14th, 1898.

"Æquam memento rebus in arduis
Servare mentem."—Horace, Book ii, Ode iii.

On Appendicitis.

*A Paper read before the Abernethian Society on
November 4th, 1897,*

By T. P. LEGG, M.B., F.R.C.S.

THOUGH appendicitis is so common a disease, it is only within the last few years that attention has been prominently directed to the importance of the pathology of the appendix vermiformis and the results of disease of that organ. In 1888 Treves read a paper before the Royal Medical and Chirurgical Society "On the Operative Treatment of Relapsing Typhlitis," and from the publication of that paper attention has been given to the surgical aspects of the subject.

At the present time the chief differences of opinion among surgeons are when to operate in the acute stages, and whether the appendix should or should not be removed in all cases.

As regards the anatomy of the appendix, the relations of the peritoneum and its position are the most important.

There are three peritoneal pouches close to the appendix: (1) the ileo-colic; (2) the ileo-cæcal; and (3) the subcæcal, immediately behind the cæcum. They are of interest, as they may lodge the appendix or become the sheath of a hernia of the small intestines. (For a detailed account see Lockwood and Rolleston's paper, *Journ. Anat. Soc.*, xxvi.)

A meso-appendix is almost always present. It is a double fold of peritoneum, and contains between its layers the blood-vessels, lymphatics, nerves, and a single gland into which the lymphatics of the appendix pour their contents. Its length varies; Lockwood and Rolleston state that it rarely reaches more than half or two thirds the length of the appendix. Treves says "it may in the fœtus extend to the tip of the appendix, but in the adult it reaches only to the centre of the tube or the junction of the middle and distal thirds."

In connection with the vascular supply it should be noted that there is only one artery derived from the ileo-colic; it runs along the free border of the mesentery.

Not infrequently the appendix is curled on itself as if the mesentery were too short for it.

The position the appendix occupies is subject to wide variation; and probably it varies at different times in the same person, as it is a moveable body; the length of the mesentery as well as its breadth, and the length of the organ, doubtless determine in great measure where it lies. The appendix is almost always an intra-peritoneal organ, which is of great importance when considering the position of an abscess connected with it. Usually it is found behind the lower end of the ileum, with its extremity pointing to the spleen. Frequently it hangs over the brim of the pelvis. In other cases it passes right across the sacrum or last lumbar vertebra; not infrequently it is retro-cæcal, and can only be seen on turning up that organ; lastly it may come off from the lower end of the cæcum, as in the fœtus.

Structure.—The appendix is almost entirely composed of lymphoid tissue, which is diffuse and not in isolated masses or groups. Lieberkühn's follicles are present even to the tip. Surrounding the mucous membrane are two layers composed of fibrous tissue and some muscular fibres, forming an outer and inner coat, and surrounding all is the peritoneum.

Function.—The function of the appendix is unknown. It has been suggested that its use is to lubricate the adjacent cæcum, where feces are apt to accumulate. In the fœtus it is not infrequently distended with meconium, and in the adult faecal concretions are found, which have produced no effect whatever. It has a distinct and pervious lumen throughout its whole length in the majority of cases; in old people in many instances it is only partially pervious, and in the canal is a certain quantity of mucus with semi-fluid faecal material; faecal concretions not being uncommon—50 per cent. of 321 cases examined by Fitz. The appendix is the remnant of the elongated cæcum of the lower mammals. In the gorilla and chimpanzee it exists as in man—a process attached to the cæcum, and representing the lower part of that organ. (In birds a double cæcum is met with.) It is also of interest to know that in the higher apes morbid conditions are by no means uncommon (Bland Sutton).

Ætiology.—Appendicitis occurs at all ages, but the most common time is from 10—30 years. During the last five years 156 of the 220 cases admitted to this hospital occurred during that period of life, the figures being 37 cases 10—15 years, 54 cases 15—20, and 65 cases 20—30 years. There was only 1 case under 5 years, and that was in 1893, and he was admitted for strangulation of the intestine by an

adherent and ulcerated appendix; he was 4 years old. In later life the disease is not so uncommon; there were 12 cases in patients of 40—50, and 4 in patients of 50—60, and some of these were first attacks. Males are much more frequently attacked than females; the statistics of this hospital during the last five years show that nearly four males were admitted to one female, or more accurately 79.5 per cent. of the cases were males, and 20.4 per cent. females. This agrees very closely with Treves, who says about 78 males to 22 females is the proportion of the sexes. The frequency of attacks varies enormously. Many cases after having had one attack recover completely; others are reminded of their trouble by any indiscretion in diet or by constipation. But a large proportion of cases relapse, and the number of relapses varies both as to frequency with which they occur and the severity. The percentage of relapses has been estimated at 23.6 per cent. by Dr. Hawkins, and 44 per cent. by Fitz. Treves considers this latter the more accurate figure. There are cases on record with as many as twelve or fifteen attacks in a year or eighteen months; or one attack may occur, and then freedom for several years. Further, some of the relapses may be quite trifling, and others very severe, and any one of them may end in suppuration, or cause the speedy death of the patient.

As to the question of foreign bodies and their relation to appendicitis much has been written; many so-called foreign bodies are not anything of the kind, and Treves goes so far as to say, "I have never found such seeds or fruit-stones in the appendix, and I believe them to be exceedingly rare." Among the varieties of foreign bodies met with in the appendix are pins, nails, &c.; that these do occur occasionally there can be no doubt, for in all museums are such specimens to be seen, and they have been found during operations. But as regards "grape seeds," "cherry stones," "orange pips," and "date stones," there is no doubt that in the larger number of cases these are really faecal concretions, and on section they are clearly demonstrated to be so. They consist usually of a nucleus formed of dried mucus, and outside layers composed of carbonate of lime, phosphates of magnesia and lime, and a little faecal matter. In size they vary from a "grain of wheat to a date stone." In other cases they are really faecal pellets, hard or soft.

Though these bodies are so frequently found in connection with cases of appendicitis, many surgeons consider them the result of a catarrhal process, rather than the cause. Certain it is they are frequently found post-mortem in otherwise apparently healthy appendices, and in patients who have had no symptoms during life. And those who consider them of secondary importance look upon the retention of mucus as a chief cause of the disease, the appendix being regarded as a diverticulum of the intestine which readily allows the stagnation and accumulation of faecal matter. This, with the mucus, leads to fermentative and putrefactive changes, setting up catarrhal inflammation, which may be followed by ulceration and perforation, or thickening of its walls, which is most commonly met with in the recurrent forms. The faecal concretions or foreign bodies must tend to keep up and excite recurrent inflammation.

Constipation alone is not a sufficient cause of perityphlitis; constipation is more common in women than men, yet the disease occurs four times as often in men as women. As a factor it may be of importance, and more especially so in cases of relapsing perityphlitis, especially when at the same time an indigestible or unmastered meal is present.

A history of injury is obtainable in a few of the cases, usually a blow or strain. The symptoms may come on rapidly, and in some of these cases a past history of constipation and pain is obtainable, which may have been a slight attack, and the injury merely relighting up old mischief.

Among other causes, Dr. Haig believes gout to be exceedingly common, so much so that if all cases were at once treated by salicylates, further troubles requiring surgical interference would be rare.

The classification of the varieties of appendicitis has been done in several ways. Usually three varieties—the simple, perforative, and relapsing—are described; to these may be added the specific varieties—typhoid, tuberculous, actinomycotic, and the gouty.

In the last volume of the *Hospital Statistics*, Mr. Berry divides all the cases admitted during the year 1896 under the following heads, and for clinical and practical purposes this list includes all the varieties:

- (1) Mild cases without suppuration.
- (2) Chronic relapsing cases without external suppuration.
- (3) Acute with suppuration.
- (4) Chronic with abscess.
- (5) Chronic with strangulation of intestine by adhesions.
- (6) Old appendicitis with sinuses.

As to the frequency of these varieties, those included under mild

cases without suppuration far and away outnumber all the others, considerably over 50 per cent. coming under this head.

The symptoms of appendicitis are well known. The first and one of the most prominent is pain in the right iliac fossa, which may be localised here, but in other cases it is general and diffuse, or referred very frequently to the umbilicus. As the intensity increases it becomes more and more localised to the right iliac fossa, and at any rate is most marked here in those cases where it is diffuse. Now and again it is referred to the left iliac fossa. The onset is generally sudden,—in some cases there is a preceding uneasy sensation in the belly. Besides the pain in the belly, it radiates to the back, the thighs, and may, in some cases, extend into the testicle.

Tenderness is a marked symptom in all cases; it may be all over the belly, but is most marked in the right iliac fossa, and a spot, called McBurney's point, can frequently be demonstrated as a point of maximum intensity. This point is generally on a line drawn from the anterior superior iliac spine to the umbilicus, and about $1\frac{1}{2}$ inches, or halfway, from the spine. As the disease advances this tenderness becomes more marked, so that not even the slightest pressure in the most acute cases can be borne. Further, this tenderness is persistent, and lasts long after all acute symptoms have passed away, and convalescence is established. It should, however, be noticed that this tenderness may be much more marked in non-suppurating cases than in those with suppuration, so that its degree is not a sure guide to the amount and extent of inflammation going on.

As a rule, the bowels are constipated, though they may act daily up to and during the attack, even without enemata or the use of aperients. Diarrhoea is present in a small number of cases; there was a case in Charity in May this year with well-marked diarrhoea; the patient died, and, post mortem, general septic peritonitis due to a perforated appendix was found. Vomiting is a variable and irregular symptom; it generally occurs at the onset, but is rarely severe or prominent, and may be generally controlled by suitable treatment.

Fever is generally present, but the variations in temperature are marked. A temperature of 103° or 104° may occur in those cases which yield readily to treatment, and do not suppurate. In such cases the temperature generally falls in twenty-four to forty-eight hours. In other cases, with abscess and general peritonitis, the temperature may be not higher than 100° or 101° . Indeed, several such cases occurred in the hospital last year. There was a boy in Charity in the early part of this year who had a large abscess and a temperature of 104° before operation; afterwards it fell, in the course of twelve hours, to 99° , and though general peritonitis set in, and he died in about thirty-six hours, his temperature never rose above 100° . So that too much stress must not be laid on temperature as an indication of the presence or absence of pus. On the other hand, the temperature may rise to a great height— 105° or 106° —with general peritonitis, before death.

The condition of the pulse is, perhaps, of more importance than the temperature; a small, thready, rapid pulse indicates grave disease, and, combined with a temperature of 100° or 101° , a bad prognosis. A pulse which diminishes in frequency and increases in volume is a good sign; a pulse which increases after operation, becoming more thready, is a bad sign.

The abdomen is frequently distended, immobile, and rigid; this last sign being more marked in the right iliac fossa. But not infrequently these signs are absent, and the abdomen is quite flaccid, not distended, and moves with respiration, even when an abscess is present or general peritonitis. In other cases these conditions are limited to the right iliac fossa or lower part of the abdomen. As the abdomen becomes less distended and less tender, a tumour is to be felt in the right iliac fossa, the size of which is dependent on the extent of the disease; further, this tumour is dull on percussion, though not always absolutely dull. The shape of the tumour varies, and sometimes it is quite defined in outline, at others very indefinite. Its consistency varies; it may be nothing more than a resistance, or it may be hard. It is formed by inflammatory effusion matting together the intestines, distended by gas or filled with faecal material, the omentum, and the inflamed appendix. As the inflammation subsides and its products are absorbed, and the intestines emptied, the tumour becomes smaller, until finally nothing may be left at all, or only a round or elongated sausage-shaped swelling—the enlarged appendix. The size of the swelling does not bear any definite relation to the gravity of the case.

In all cases of doubt as to whether there is anything in the region of the appendix, a careful examination under an anæsthetic is indicated, and examination *per rectum*, more especially in children, will often aid in detecting a fulness or resistance in the right iliac fossa. In women *per vaginam* examination is an additional help.

Constitutionally the patient is more or less prostrate, lying on his

back with, perhaps, the right leg flexed or drawn up; the tongue is furred, in the worst cases dry and cracked. Thirst and headache are often prominent symptoms, the thirst being very persistent. With the constipation no flatus at all may be passed. The appetite is bad in most cases.

The formation of the abscess.—There is unfortunately no one sign or symptom by which the presence of pus can be definitely decided. For at first the pus is deeply seated in the iliac fossa, and it takes some time to come to the surface; and if so, it may not be in sufficient amount to give rise to fluctuation. As the abscess comes forwards the abdominal walls become infiltrated, brawny, and oedematous, and this condition, combined with the rigidity, may entirely obscure fluctuation. Nevertheless, the combination is highly suggestive. The temperature is no guide, for in the worst cases it may be subnormal or only slightly raised, and not infrequently the bursting of the abscess, with the result usually of general septic peritonitis, is the first sign of its presence, followed by speedy death. A rigor is rare.

The situation of the abscess depends on the position of the appendix; in most cases it is in the right iliac fossa, and comes forward above Poupart's ligament, internal to the anterior superior iliac spine. In other cases it is mostly situated in the pelvis, in Douglas's pouch, as when the appendix is hanging over the brim; if the appendix is behind the cæcum the abscess is there too, and it may be as high as the brim of the pelvis in the lumbar or hypochondriac regions, or even perinephric. Its walls are formed by matting together by lymph of the small intestines, cæcum, omentum, mesentery, and appendix. The pus which is contained in it is generally exceedingly foul, with a fecal odour; not infrequently free gas is present. Besides the main cavity, pockets or diverticula are very commonly found. The amount of pus may be small or several ounces, usually there is three or four ounces. The time which elapses between the onset of the disease and the formation of an abscess varies. In some cases it may be only twenty-four or forty-eight hours, in others a week or still longer; a high temperature may be present for some weeks (three or four), and no evidence of pus be present. The abscess may point and burst externally, which is the most common occurrence in neglected cases; the next most common place is for it to burst into the bowel, generally the cæcum, and lastly, the general peritoneal cavity. It may track in all sorts of directions, simulating a psoas or a nephritic abscess. Primarily the abscess is intra-peritoneal, as from the relations of the appendix to the peritoneum it must be; secondarily it becomes shut off from the general peritoneal cavity by the adhesions. But some abscesses may be extra-peritoneal from the onset.

In the chronic relapsing cases a small collection of pus quite shut off may be found, or the pus may be in the appendix itself. There was a case in the hospital this year where the appendix was found thickened, and in the mesentery a suppurating gland. This gland was possibly tuberculous. It was removed; the cavity left was scraped and touched up with the actual cautery, the patient making an excellent recovery.

Here it may be mentioned that the formation of an abscess does not lead in all cases to cure, and this has been put at about 5 per cent. of all cases operated on, in which simple incision and drainage only were done. As a rule, the relapsing abscess appears in a short time after the wound has healed (this is generally three or four weeks), and in most cases they are due to too early removal of the tube, allowing the external wound to close before the abscess cavity is soundly healed, thus allowing pus to accumulate in the depths. In other cases the abscess does not form again for some months after the primary one, and in these cases it is due to some suppuration taking place about the remains of the appendix, or some concretion left behind. Thus in June, 1896, a boy was in this hospital with acute suppurative appendicitis; the abscess was opened and drained; tube removed fifth day, and the wound healed in thirty-one days. Five months later he was readmitted with a second abscess; this was opened, and an ounce of pus let out; no search was made for the appendix, but a few days later two inches of it sloughed out, and the boy left the hospital in thirty-five days with the wound soundly healed. In the *Lancet* for January 30th, 1897, there is a case reported in which an abscess formed four times, and each time it was opened and drained. The last time it burst spontaneously, and some tissue like "pieces of appendix" came away. It then healed soundly.

A patient who has once had a perityphlitic abscess is very unlikely to have another attack of perityphlitic, the reason being that the appendix is cast off as a slough or in the debris, or it becomes destroyed and its cavity obliterated by inflammatory material.

Pathology.—Mention has already been made of the part which concretions and foreign bodies play in appendicitis. Fitz of Boston,

out of 321 cases, found fecal concretions present in 50 per cent., and foreign bodies in 12 per cent. Treves says foreign bodies are present in 3 per cent., Murphy 3.5 per cent. In 400 post-mortems of all kinds, Ribbert found them in 10 per cent. More important is the part which micro-organisms play, and the most frequently found is the *Bacillus coli communis*. In thirty-four out of thirty-five cases this organism was found. These micro-organisms are, perhaps, the most important factor in the development of the disease, but not in its primary origin. Normally they are found in human intestines, and if any part becomes inflamed they become very virulent. In some cases they occur in pure culture, in other cases in association with streptococci, and much less frequently with staphylococci.

This same organism is also found in the exudation of the general peritonitis, and it is not necessary that in all cases of general infection a perforation of the appendix should be found, for the bacilli have the power of passing through its walls when their vitality is lowered by inflammatory processes. The extent of peritonitis will depend on the extent of the invasion by the bacilli; a sudden, rapid, and large invasion will lead to wider mischief, and produce more marked symptoms than a slow and gradual invasion. It is not uncommon to find the whole peritoneum involved, even that portion between the diaphragm and liver; in other cases the peritonitis may be limited to the lower part of the abdomen or the iliac fossa only, and in these cases death may be very rapid, only few signs being present post mortem. We must here assume that the poison was so virulent that death occurred before the physical signs had time to develop. The amount of effusion varies; usually it is not very great, and may be serous, sero-fibrinous, or purulent.

The actual condition of the appendix varies according as to whether it be met with in the acute stage, or in the relapsing cases. In the former it is enlarged, soft, very red, and acutely inflamed, covered by more or less lymph; adhesions may be completely absent, or so slight and slender as to be readily broken down. The whole organ may be gangrenous or separated as slough, and this may have happened in twenty-four hours. In other cases the gangrene may be limited, and in patches. Perforation may take place at any spot, and lead either into the general peritoneal cavity or into a part shut off by adhesions; the perforation may be of any size or shape, and occurs in 60–70 per cent. of all really acute cases; it is generally situated near or at the tip.

If an abscess be present the appendix may be found lying loose in its cavity, or it may be found projecting from the walls. In other cases it is intimately bound up with the adhesions, and not to be found except on careful dissection.

In chronic relapsing cases, numerous adhesions are generally found, though they may not be present. The appendix is thickened, more especially the lining membrane; the cavity may be distended so as to become cystic, or it may be obliterated in part or wholly; kinking is not infrequent. The mucous membrane may be ulcerated in one or more places and nearly perforated. The secretion is increased in amount, and may be actually purulent; concretions are not infrequent. The adhesions may be so dense and firm that the appendix is not to be distinguished.

(To be continued.)

Two Cases of Malignant Disease of the Stomach.



HESE two fatal cases of malignant disease of the stomach, one followed by intestinal obstruction, the other by sub-phrenic abscess, are reported by permission of Dr. Brunton.

CASE 1. Carcinoma of stomach and obstruction of transverse colon by a band of adhesion.—H. L., 43, a coal-heaver, was admitted into Rahere Ward on October 15th, under Dr. Brunton's care, complaining of weakness and a swelling of the stomach.

History of present illness.—Patient was quite well up to beginning of June, 1897, when he felt persistent pain in epigastrium, not increased after food, nor relieved by vomiting. Occasional vomiting had occurred (about once a fortnight), which had at times been "black," and he had also occasionally passed "black" motions; he never brought up or passed pure blood. He has lost flesh rapidly in last six months; his weight used to average 12 st. 6 lbs., but is now less than 8 st.

Present condition.—Sallow complexion; much wasted; neck very thin; aortic arch felt in supra-sternal notch. Chest tender on percussion; right lung resonant as far as fifth rib in front, then a line of dullness for one and a half inches, and below this tympanitic resonance continuous with abdominal resonance; breath-sounds natural; left lung, percussion note impaired at the apex, and the breathing accompanied by sibilant sounds. Heart natural. Pulse 92, regular, good volume and tension; temp. 99°. Abdomen tense, no dilated veins; tympanitic resonance all over. No thrill felt, or change of resonance in the flanks on altering position. A large indefinable mass is felt reaching almost to Poupart's ligament on the right side, with no definite edge. The tenderness and tense condition of the abdomen prevent a satisfactory observation. No oedema of the legs. Urine 1022, acid; bowels open after H. Sennæ Co. Examination of rectum reveals nothing. Maximum abdominal girth 33½ inches.

October 17th.—Patient vomited a quantity of foul-smelling brown fluid of a thick soupy consistency, acid in reaction. This occurred twice also in the evening, with some relief of the pain. An injection of morphia was given at 6 p.m. He slept fairly, but hiccough and flatus by the mouth were troublesome. Unable to pass flatus *per rectum*.

18th.—Thrill felt across lower part of abdomen. Severe pain, relieved by morphia. The stomach was washed out, but only a few flakes of food were brought away.

19th.—More pain in the night. Vomited twice.

22nd.—Patient passes scarcely any motions, and very little flatus *per anum*, and vomits nearly all his food. The distension has increased, and the abdomen is tympanitic all over. No increase of ascites. Sir Thomas Smith and Mr. Butlin were called in; they were of opinion that the obstruction was probably between the splenic flexure and the sigmoid, and that colotomy either of the transverse or descending colon was indicated. Patient, however, refused an operation.

23rd.—Patient weaker and depressed. Pain for the most part yielded to morphia injections. Vomiting practically continuous; no food wholly retained. Many enemata were tried (simple, dill water, asafoetida), and a fair amount of faecal matter came away in some instances, but scarcely any flatus was passed.

24th.—Patient remained greatly distended. Vomiting distinctly feculent in odour and appearance. Respiration failed, and patient died at 7.30 a.m.

Post-mortem.—*Abdomen*: when opened much gas mixed with some red fluid came spouting out. In the peritoneal cavity there were three pints of ascitic fluid. The entire peritoneum was dull and injected, with patches of yellow lymph here and there, and in the pelvis some faeces. The small intestine was blown up to three or four times its usual size, and beneath the abdominal wall three coils of it placed side by side reached from the liver to the pelves, and completely obscured the underlying contents. When the small intestine was removed the cæcum was found to be greatly distended by gas and faeces; it was five or six times its usual size, and on its inner surface there was a small perforation through which faeces could be pressed. The peritoneal coat over part of the cæcum had given way. The ascending colon was also distended, and the cause of obstruction was found in the transverse colon close to the hepatic flexure; here the intestine was nipped in two different places by cicatricial tissue in association with enlarged glands in the neighbourhood. There was no growth in the colon itself, the constriction admitted the little finger, and the mucous membrane was not ulcerated. The stomach was not dilated; the œsophageal half was infiltrated throughout its whole extent by new growth, so that the wall was about one sixth of an inch thick. The pyloric end was natural, and a fairly sharply defined line could be made out between the two halves. Some of the veins were dilated, but no ulceration was found. The glands in the lesser omentum were enlarged, white, and hard; similar glands were found in the mesocolon, and in the aorta just below the origin of the celiac plexus. There were no growths in the lungs, liver, spleen, kidneys, and pancreas. The glands around the head and tail of the pancreas were enlarged by growth. Both lungs were œdematous, the left almost universally adherent, with about a pint of fluid in the pleura; the right pleura contained a little fluid.

CASE 2. Carcinoma of stomach; perforation; subphrenic abscess and secondary growths.—John B., æt. 44, engineer's labourer, was admitted into Rahere under Dr. Brunton's care on August 25th, 1897, complaining of pain in the left side of the chest.

History of present illness.—March 25th, 1897, patient fainted while at work.

On March 26th he vomited about half a pint of blood, and was admitted to Rahere, where he remained six weeks, and was washed

out three or four times with great relief. He then went to Swanley, and returned as an out-patient, still complaining of pain in chest.

August 16th, 1897.—Vomited after every meal, the vomit being "like beef tea."

24th.—Vomited three or four times; great pain in splenic region.

25th.—Hæmatemesis (slight).

Past history.—Dyspepsia for two years; enteric fever, aged twelve; has lost 2½ st. in last two years.

Present condition.—Patient very weak and wasted, face almost bloodless. Tongue moist, slight fur. Temp. 99.2°.

Chest: thin, moves well. Percussion note is impaired below the level of the nipple on the left side in front, and in the axilla. Over this area breathing is weak and vocal vibrations absent, and to this area the pain is referred.

Heart: apex beat in fifth space in nipple line. Cardiac dullness upper border of third rib and left border of sternum.

Abdomen: on admission the abdomen was flaccid, and moved freely. The percussion note was tympanitic all over, the stomach area being increased. Liver dullness did not extend below the ribs. There was tenderness in the splenic area. Patient passed some blood *per rectum* after enema.

12 noon.—Since admission the abdomen has become somewhat distended and firm, resisting palpation and moving less. Pain in the side has increased. *Per rectum*, nil.

3 p.m.—Patient was seen by Dr. Church, and a needle was passed into the tenth interspace (left) in the posterior axillary line, and about 2 c.c. of blood drawn off. A perforate ulcer was thought unlikely, and feeding by the mouth advised.

6 p.m.—After an injection of morphia patient became free from pain, and slept.

August 30th.—Has passed dark-coloured blood in motions since admission. Has had no vomiting. Pain in side continues. Still very anæmic. Temperature normal.

September 13th.—Signs and symptoms continue the same. Oedema of the legs well marked.

25th.—Two pints of clear serous fluid drawn off by puncture in seventh space (post-axillary line).

October 3rd.—Dullness now extends to the third rib in front. Left lobe of liver felt to be enlarged. There is a little blood in the stools, no vomiting.

12th.—Two and a half pints of blood-stained serum drawn off from left pleural cavity. Oedema of legs and hands increasing.

26th.—Pain much less. Temperature has continued normal.

27th.—Patient distinctly weaker. Change rather sudden. He complains very little of pain, and is very apathetic.

29th.—Patient sank very rapidly. Pulse imperceptible for about twenty minutes. Respiration very slight and sighing. Corneal reflex present till 4.30, when patient died.

Post-mortem.—*Lungs*: right 24 ounces. Some recent adhesions in connection with patches of new growth in the lung. Fluid (about ½ pint) in pleura. Left 15 ounces. Adherent to apex, diaphragm, and mediastinum. Collapsed owing to a large serous effusion, greenish in colour, not blood-stained, and containing flakes of lymph. Both lungs studded over the surface with small, white, hard nodules, any size up to a hazel-nut.

Heart: probably somewhat atrophied, and brown in colour. Mitral and tricuspid valves somewhat thickened.

Abdomen: no general peritonitis. Recent lymph and old thickening round spleen. About one pint of greenish ascitic fluid.

Stomach: on opening the stomach along the lesser curvature it was found full of "coffee-grout" grumous material, and when this was washed away a large round hole (1½ inches in diameter) was seen at the cardiac end on the greater curvature. This hole opened into a cavity which was bounded above and behind by the vault of the diaphragm, in front by the left lobe of the liver, the greater splenic omentum, and spleen; below it extended to the pancreas and just behind it, and in front of the upper part of the left kidney. The edges of the hole were heaped up, and there was thickening for some way round. The walls of the cavity were ragged, and in parts sloughing. New growth in small patches was seen on the peritoneum in the neighbourhood. The contents of the cavity were similar to those of the stomach.

Intestines: the splenic flexure was imprisoned by adhesions round the abscess, but no ulceration anywhere.

Liver: fatty. A few nodules of growth, none larger than a shilling.

Spleen: a few small round patches on its surface, but in its substance only such as occur from infarction.

Glands: those near the pancreas and round the celiac axis were enlarged, white, and hard.

Kidneys: one rounded white growth in one of the pyramids.

Boys and Firearms.

By HAROLD MEAKIN, M.D.Lond.

"There is a peculiarity, but no mystery, in gun-shot wounds."

JOHN BELL.

THE possession and use of pistols by small boys has recently been the subject of much correspondence in the daily press. The experience of a house surgeon in regard to wounds caused by so-called "toy" pistols may therefore be of interest. In the first place such wounds are in no sense a rarity, and few house surgeons finish their term of office without having a considerable number under their care. I refer to accidental wounds caused by "toy" pistols in the hands of small boys, and do not include wounds caused by the larger weapons generally used by adults.

I have before me a series of these small but dangerous weapons, taken *aut vi aut fraude* from their wounded owners. It is a curious collection. Differing slightly in construction, they are alike in bad workmanship and cheapness of appearance, and particularly in the absence of any maker's name. The barrels vary in length from two to two and a half inches, with a bore of .22, firing a rim-fire cartridge with a round bullet. The hammers can be placed on half or full cock, but the trigger drops them from either position with equal ease. There are no trigger guards. The total length varies from four and a half to five inches. Messrs. J. and W. Tolley, of Bond Street, to whom I have submitted some of them, tell me that they are of American manufacture in distant imitation of the "derringer" pattern, and that they are probably supplied to the public at a cost of about two shillings each.

In spite of the small size of the weapon, it carries with quite enough force to cause serious injury. I have myself put a bullet through a deal plank $\frac{3}{8}$ inch in thickness with one of them.

From the description it is not difficult to realise that accidents are exceedingly likely to happen with such a weapon. In the active fingers of a small boy such a short barrel can be directed to all points of the universe in succession, in an incredibly short space of time, and it becomes a source of surprise that accidents are not even more frequent.

The situation of the wound is interesting. If, as is usually the case, the holder of the pistol wounds himself, the wound is nearly always on the palmar surface of the left hand, just at or near the base of the forefinger. Entering at this point the bullet either passes straight through the finger, sometimes splintering the proximal phalanx, or passes up towards the wrist on either the palmar or dorsal surface of the hand. The position of the wound can be explained by the fact that at the time of the accident the boy is raising

or lowering the hammer with his right hand, and holding the barrel in his left. The spring is too strong for his small thumb, and the hammer slips from his grasp.

Occasionally an envious and admiring friend receives the bullet, but this seems to be the exception. Under these circumstances I have seen bullet wounds in the arm, leg, and face, but happily my experience does not include any fatal case.

As regards the progress of the wounds, with the exception of a very small percentage they healed without suppuration. This was no doubt due to the fact that great care was taken to clean and disinfect the surrounding skin,—special attention being paid to mechanical as well as chemical means. The wound was scrubbed vigorously with a nail-brush, hot water and soap being freely used; this was followed by syringing with a 1 in 1000 solution of perchloride of mercury, and the application of the usual dressings wrung out of the same lotion. A splint and sling completed the treatment.

In one case the bullet had separated a longitudinal splinter from the basal phalanx of the left forefinger, and this was sticking out of the wound of exit on the dorsal surface. The fragment of bone was removed, and the wound—treated in the usual manner—healed without suppuration.

In those cases in which there was no wound of exit the bullet could sometimes be felt beneath the skin on the opposite side of the hand, and was easily removed through a small incision; in others, where the bullet was more deeply buried, the Röntgen process was resorted to, but though it showed a shadow of the bullet, the photographs were not, I am sorry to say, of much service in localising its position, and so assisting in the ultimate attempt at its removal.

The age of the patients varied from nine to seventeen. Inquiries as to the source of the weapon generally elicited the answer that it had been bought from some "other boy." I don't think any patient ever admitted that he was the original purchaser.

I am told that these accidents are commoner in the Casualty Department of St. Bartholomew's than in those of other London hospitals. Certainly I saw fewer while House Surgeon to the Metropolitan Hospital than while House Surgeon to this Hospital, but even at the former hospital they could not be called rare. It is possible that the boys of Clerkenwell are of a more warlike disposition, or that they are less skilful in the use of their weapons, than the boy warriors of other districts.

It is strange that such dangerous forms of amusement should be permitted, but the police say they have no authority to interfere unless *intentional* harm is done.

In one instance, where a girl of seventeen was shot in the side of the face, the police were notified from the Hospital, since the ultimate recovery of the girl seemed uncertain; but

they said they were unable to act, as the wound "seemed to be the result of an accident."

It appears that excise officers alone can take action against unlicensed persons who carry firearms, and it seems doubtful whether these small weapons come within the scope of the Licensing Act. It is at least certain that great numbers of them are in the possession of the small boys of London, who presumably are unlicensed.

A Case of Retro-oesophageal Abscess.

By G. S. HAYNES, M.R.C.S., L.R.C.P., House Physician to the Metropolitan Hospital, and formerly House Surgeon, Belgrave Hospital for Children.



H. G.—, a boy *æt.* 4 years, was admitted into the Belgrave Hospital for Children under Mr. Waring on May 18th, 1897, with the following history.

On March 29th, 1897, he was first brought to the hospital for "lumps in the neck." He was found to have slightly enlarged cervical and submaxillary glands, large tonsils, and adenoid vegetations. The mother was advised that the latter had better be removed when patient was in a better state of health, he then being convalescent from an attack of whooping-cough. He was given tonics and attended as an out-patient.

April 23rd the operation was further postponed, owing to the boy having some slight coryza and bronchitis. This cleared up, and on May 18th patient was admitted. It was noticed that his breathing was somewhat noisy and difficult; the mother said this had come on in the last week and was getting worse. The temperature was 98°8'. It was supposed that the dyspnoea was caused by the enlargement of the tonsils, which met in the middle line. Chloroform was administered, and some adenoid vegetations with the enlarged tonsils were removed. Patient took the anæsthetic well, and nothing extraordinary was noted.

May 19th.—The dyspnoea was more marked, and there was some recession of the lower ribs. Patient vomited twice after food.

20th.—About midday the dyspnoea became urgent, so tracheotomy was performed under chloroform. The child stopped breathing before the trachea was opened, but respiration was restored artificially. A silver tube was inserted, the dyspnoea being entirely relieved. A good deal of thick green viscid mucus was coughed up. In the evening after the operation the temperature rose to 101°6'.

21st.—Patient was more comfortable and had no dyspnoea, respiration being 30, pulse 112, good volume and tension. Temp. 99°. He vomited twice after milk, and coughed up a good deal of mucus through the tube.

22nd.—The temperature last night 100°6', but this morning was normal. An unsuccessful attempt was made to leave the tube out, the dyspnoea becoming well marked at once on removal. Patient vomited twice after milk.

23rd.—Patient looked fairly well, though he appeared to be losing flesh. He slept well, but took food badly, and occasionally vomited after it. The wound showed slight signs of suppuration, and the temperature was 100°. Another unsuccessful attempt was made to leave out the tube.

24th.—The child was drowsy and irritable. Temp. 99°6'. Patient coughed up a good deal of viscid mucus, which was on one occasion slightly blood-stained. He took food badly, and vomited after it three or four times in the twenty-four hours. He was losing flesh and strength markedly. A rubber tracheotomy tube, size No. 1, was inserted in place of the silver one, a free opening being made in upper surface of tube.

27th.—To-day it was noticed that milk given by mouth flowed out through the tracheotomy tube. Patient had a great aversion to milk foods, but there was apparently no dysphagia, as he would eat a biscuit eagerly. The wound was granulating up, and the skin round it looked red and swollen. Temperature the last two days reached 101°; to-day it was 99°8'. Dyspnoea became urgent in about fifteen minutes on leaving out tube.

Subsequent progress.—Patient went on in much the same manner till the second week in June. He vomited occasionally after food and

had a great dislike to taking it, but there was never any dysphagia or regurgitation of food. Several attempts were made to leave the tube out, but on every occasion dyspnoea occurred, coming on sometimes in a few minutes, sometimes after half an hour. Sometimes it was noticed that the tube was more difficult to replace, and would go in with a jerk as though some obstruction were suddenly overcome. The wound granulated up satisfactorily, though the neck round the incision was sometimes red and swollen.

On June 4th chloroform was administered and the larynx examined with the laryngoscope. A clear view of the cords was obtained. They appeared slightly congested but otherwise natural. Nothing was seen to account for the dyspnoea which occurred while the patient was anæsthetised on closing the opening in the trachea.

On June 11th it was noticed that the child would frequently put his fingers down his throat, as though he were in pain. He also tried to pull the tracheotomy tube out. He was wasting more than could be accounted for by his anorexia and occasional vomiting.

From this day the patient got rapidly worse. He vomited almost invariably after food, and became very weak and exhausted. There was good air entry throughout, and dyspnoea never occurred while the tube was in place and free. The patient's temperature between May 27th and June 14th was only once (on June 3rd) over 100°. It was usually about 99°. On the evening of June 14th the temperature was 101°2'. On June 15th in the evening the temperature rose to 103°, and pulse became rapid, feeble, and irregular. Patient had three convulsive attacks, and died after the last one at 6 a.m. on June 16th.

Post-mortem examination.—The body was considerably wasted. The usual incision was made, and the tongue and floor of the mouth brought downwards with the pharynx and larynx. While removing the oesophagus from the vertebral column an abscess cavity was opened. This was found to contain about a drachm of thick yellowish pus, and to be situated between the oesophagus and the last two cervical vertebrae. It was about 1½ inches long by ½ inch wide, and did not communicate with the oesophagus. Its walls were thick and rough, and the anterior surfaces of the bodies of the sixth and seventh cervical vertebrae were roughened and carious, the discs on either side of the seventh being eroded. The tracheotomy wound through the upper two tracheal rings was on a level with the centre of the abscess cavity. A small ulcer was found on the anterior wall of the trachea about one inch below the opening, evidently caused by the tube being pressed forward by the bulging of the abscess.

The submaxillary lymphatic glands were enlarged but not caseous. The lungs were somewhat congested. No naked-eye evidence of tubercle was found in any organ. The vertebrae were sent to the Pathological Department of the JOURNAL for examination, and the following report has been received:—"On microscopical examination the tissue from specimen of carious vertebrae proved to be typical tubercle."

Remarks.—The case is one of some interest, owing to its rarity, and to the difficulty of diagnosis.

In Holt's book on *Diseases of Infancy and Childhood*, retro-oesophageal abscess is said to be commonly due to Pott's disease of the lower cervical or upper dorsal vertebrae, the symptoms being obscure, and an exact diagnosis not often made during life. There is rarely dysphagia, but in all cases symptoms of irritation of the pneumogastric. In most cases there are no external signs of disease. The prognosis is exceedingly bad, death usually resulting from pressure on the vagus.

Donkin, in his *Diseases of Childhood*, "very strongly contradicts the prevalent belief that either spinal caries or the scrofulous condition is a common cause." A certain number of cases follow measles or scarlatina, but the majority are traumatic in origin, due to laceration of the oesophagus by foreign bodies, such as fish-bones, crusts of bread, &c.

In *Pediatrics* for June 1st, 1897, there is a report of the Ninth Annual Meeting of the American Pediatric Society, when a paper was read by Dr. J. P. C. Griffith on "Retro-oesophageal Abscess," in which he reported a case, and emphasised the difficulty of diagnosing this condition during life. It was not necessary to dwell at any length upon the symptoms,—in fact, there seemed to be none absolutely characteristic. If analysed, dyspnoea at least was present in nearly all cases. "This seemed to be the result of reflex irritation." "As to caries of the spine, he found it mentioned in seven cases, and proved by autopsy to have been present in two."

A discussion followed, and a few cases were reported.

I have not gone thoroughly into the literature of the subject, and I find the disease barely mentioned in the ordinary text-books. As far as I can ascertain, the following facts may be taken as a summary of the condition.

1. That it is essentially one of infancy and early childhood.
 2. That its causation may be primarily due to tuberculous disease of the bodies of the lower cervical or upper dorsal vertebrae, or to abscess formation in the pre-vertebral tissues, due to laceration of the wall of the oesophagus, with possibly consequent caries of the vertebrae.
 3. The symptoms are obscure, but dyspnoea, vomiting, and wasting were prominent in this case.
 4. The diagnosis is exceedingly difficult.
 5. The most rational treatment is external incision and drainage.
 6. The prognosis is exceedingly bad.
- I am indebted to Mr. Waring for his kind permission to publish these notes.

Ophthalmic Notes.

Four cases of Injury or Disease of the Orbit, recently in the Ophthalmic Ward under the care of Mr. Vernon, and reported with his permission.

1. *Extensive hæmorrhage into orbit; recovery.*—W. D—, æt. 1½, was brought to the surgery with the history that on the previous day his brother hit him in the right eye with a stick. On examination there was found a slight degree of proptosis, and a small speck of blood beneath the conjunctiva to the outer side of the cornea (the true "blood-shot" eye). Next day he was brought up again in such a condition as to suggest a suppurating eyeball; there was extreme proptosis, the lids purple, swollen, and so tense that they could not be separated. The mother now volunteered the further history that ten days ago the sash-line of a window breaking let the window down on the child's head; that the child's head was bruised, but the eye was not damaged. The child was at once admitted, and on examination under chloroform the subconjunctival hæmorrhage was found to have extended all round the cornea, which was itself clear; there was a slight abrasion of the conjunctiva of the lower lid, and much chemosis.

For several days the proptosis continued slightly to increase, the lids becoming more and more tense, not covering now the oedematous ocular conjunctiva, which protruded from between them. No movement of the eye was possible; the pupil reacted sluggishly. In other respects the child appeared quite well. His appearance was very remarkable. Six days after admission the condition began to improve; the lids closed again; the eyeball began to retreat, and to regain its mobility. The fundus could now be seen to be normal.

In three weeks the condition was almost precisely the same as when seen in the surgery the first time.

The interest of the case lies in the following points:—(1) the question which injury was responsible for the hæmorrhage; if, as seems more probable, it was the injury to the cranium, the length of time before the proptosis occurred is remarkable; (2) the suddenness of the proptosis, and the extreme grade to which it reached without any other untoward symptoms; and (3) the absence of any signs of pressure on the optic nerve.

2. *New growth in orbit.*—H. T—, æt. 41, a farmer, admitted November 10th, gave the following history. Six weeks ago a bramble struck him across the right eye: he pulled out a piece an inch or so in length from a wound in the upper eyelid, which suppurated, was incised, and healed a week later. Since this time he has had a gradually increasing swelling in the right orbit. Patient further states that nine months ago a tumour in his left loin was removed. His doctor told him that this was a "fatty tumour," but privately communicates his opinion that it was a "spindle-celled sarcoma."

The patient is a healthy man with sound organs. He says his sister died of "cancer." The right eye is protruded to the extent of half an inch. On its outer side both above and below is felt a hard, slightly elastic mass; and on the external wall of the orbit is a swelling extending backwards into the temporal fossa, and upwards towards the scalp, its most prominent part being an inch behind the external canthus; the skin over it is reddened; there is no tenderness or fluctuation, and no enlargement of lymphatic glands. The movements of the eyeball are impeded in all directions, with consequent diplopia; the veins of the conjunctiva and sclerotic are injected. Distant vision is reduced to $\frac{3}{6}$; near vision to J. 19 at ten inches. There is optic neuritis in both eyes, but the vision of the left is unimpaired. The fields of vision of both eyes are uniformly contracted, not exceeding 45° on the temporal side.

On examining the back an operation scar is seen over the left wing of the sacrum; this appears quite healthy, and there is no sign of recurrence. But now another tumour is found, 6 inches by 4 inches, lying to the left of and partially concealing the dorsal spines from second to sixth; it is smooth, very resistant, not attached to the skin, and not moving with the scapula. This is probably a bony growth, and the patient says he has been aware of it for twelve months, and believes it to be increasing.

The sequence of this perplexing history is, then, briefly—(1) twelve months, bony tumour in dorsal region; (2) nine months ago, "fatty tumour" removed from loin; (3) six weeks ago, injury to orbit, suppuration; (4) four or five weeks, growth of tumour in orbit; (5) ten days, spreading to temporal fossa.

November 14th.—An exploring needle was passed in several directions into the swelling on the temple, and only drew off a little blood.

19th.—Under chloroform an incision was made along the outer wall of the orbit, into which the orbital fat at once bulged; a little deeper a mass of soft growth was found, with the lacrimal gland embedded in it; a considerable extent of bone forming the roof and outer wall of the orbit was honeycombed and crumbling away, so that a director easily passed into the temporal fossa. The wound healed by first intention. Under the microscope the growth appears to be a species of "round-celled sarcoma" of unusual character.

Prognosis unfavourable. Chances of recurrence great, and further operation hardly possible.

3. *New growth in orbit.*—L. P—, æt. 9, admitted November 3rd, was taken nine weeks ago to see an ophthalmic surgeon on account of a small lump growing at the inner angle of the right orbit. He removed a small hard growth connected with the ethmoid, and not encapsuled, and after ten days allowed the wound to granulate up. Microscopic examination gave no clue to the nature of the growth. Since the operation the right eye has looked downwards, and the child has had diplopia.

On examination the right eyeball is seen to be pushed forward; movement outward and upward is impaired. The operation scar is seen just below the eyebrow. A hard, lobulated mass is felt above the eyeball, between it and the upper margin of the orbit. There is optic neuritis in both eyes, more marked in the right.

November 5th.—Under chloroform an incision was made just below the old scar along the whole length of the lid, and a firm lobulated mass removed; at one point this was attached to the orbital plate of the ethmoid, in which a small hole was left on its removal. Microscopic examination showed it to be an "alveolar sarcoma." The wound healed by first intention, and the child has made an uninterrupted recovery, suffering no inconvenience except that she cannot raise her upper lid, and if the eye is opened she sees double.

4. *Injury to optic nerve (?) followed by optic atrophy.*—S. P—, a boy æt. 9, two years ago fell from a hayrick on to a fork, which pierced his left eyebrow and upper lid. He was seen within an hour by a medical man, who found the eyeball uninjured, but within a week he completely lost the sight in that eye.

Now there is a scar at the margin of the upper lid, and some ptosis: well-marked strabismus of the left eye upwards and inwards; the optic disc is white, and the arteries rather small. He has no perception of light in it. Probably the hayfork penetrated the orbit above the globe and wounded the optic nerve without passing on into the brain, and perhaps the inflammatory contraction around its track accounts for the unusual direction of the strabismus of the blind eye.

Notes.

MR. BRUCE CLARKE has succeeded Mr. Walsham as Surgeon in charge of the Orthopedic Department.

* * *

BY MR. WARING'S ELECTION as Surgical Registrar, Mr. Bailey becomes Senior Demonstrator of Anatomy, while the vacant Demonstratorship has been filled by the appointment of Mr. Furnivall.

* * *

MR. LI. C. P. PHILLIPS has been appointed to the con-

sequent vacancy among the Assistant Demonstrators. These changes have necessitated a rearrangement of the hours of attendance of the Demonstrators and Assistant Demonstrators in the "Rooms." It will probably be convenient if we give the new time-table here.

	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
Mr. Bailey.....	10-1	1-4	10-1	10-1	1-4	
Mr. Furnivall	1-4	10-1	1-4	1-4	10-1	
Mr. Sloane.....	10-1	1-4	10-1	10-1	1-4	10-1
Mr. Miles	1-4	10-1	1-4	1-4	10-1	10-1
Mr. Phillips ...	10-1	1-4	10-1	10-1	10-1	10-1

DR. JAMES MORRISON has been elected Demonstrator of Midwifery in succession to Dr. C. H. Roberts. It is worth recalling the fact that during Dr. Roberts's five years' tenure of this office the Gold Medal in Obstetrics at the London M.B. has fallen to a Bart.'s man on the last four occasions.

MR. T. STRANGEWAYS PIGG has been elected Demonstrator of Pathology in the University of Cambridge.

DR. H. MORLEY FLETCHER has been appointed Assistant Curator of the Museum.

THE WALSLINGHAM MEDALS at Cambridge, for the best research in Biological or Geological Science by candidates under M.A. standing, have been awarded to two Bart.'s men—Mr. V. H. Blackman and Mr. W. Morley Fletcher—both of them being scholars of our Medical School.

WE CONGRATULATE Mr. Emery on obtaining qualifying marks for the Gold Medal at the recent London M.D. examination, and Mr. Toye on securing a similar distinction in the Examination for Honours at the B.S.

MR. F. W. ROBERTSON, M.B., B.S., has been appointed Extern Midwifery Assistant.

So OUR light-hearted contemporary, the *Guyoscope*, has expired; in its last number the editor pronounces its funeral oration. Alack! it

"Did but drift a little way
Adown the stream of time."

AGAINST this lamented death may be set the birth of the *Sphygmograph* at the London Hospital. From the first number it appears to be chiefly retained in the athletic interest. Surely this could have been served more usefully by hearty co-operation with the *London Hospital Gazette* than by dividing the interests in this way. The *Guyoscope*, to give it due credit, had, at least, a more definite *raison d'être*.

THE ENERGETIC *Student*, the organ of the Edinburgh Students' Representative Council, has produced an admirable souvenir of the opening of the McEwen Hall, one well

worthy of such an interesting occasion. The photographs give a very vivid idea of the beautiful building presented to the University by Mr. McEwen's munificence. We congratulate the management on their enterprise.

THE Hospital Museum has, we understand, come in for two valuable presents. Sir Robert Craven, of Hull, has given an excellent collection of calculi, and Miss Palmer the unique microscopical preparations of the diseases of the central nervous system made by her father, the late Dr. Palmer, Superintendent of the Lincoln Asylum, and an old Bart.'s man.

DR. MORRISON'S views on routine douching of the puerperal uterus, as recently expressed in our pages, continue to excite discussion. Pressure on our space prevents the publication of a communication from Mr. L. A. Winter on this subject till our next number.

Amalgamated Clubs.

RUGBY UNION FOOTBALL CLUB.

ST. BART.'S v. R.I.E.C.

This match, played at Cooper's Hill on November 6th, resulted in a severe defeat by 2 goals, 2 penalty goals, and a try (19 points) to *nil*.

The first stages of the game were fairly even, the forwards being very evenly matched. The home outsidies combined well, and brought the game down to our 25, where from a free kick for off-side play they placed a goal. After this Bart.'s played in ragged fashion, and two more goals were obtained before half-time.

After the resumption our forwards played a much more spirited game, and on several occasions we got near the line. Eventually the ball was taken back and another penalty goal kicked against us, and just at the call of time the home team scored another try.

Body at back played well, but the other outsidies did not give him enough support in tackling. This fault should be remedied at once. The foot work of the forwards was good, and Bennett and Amsler were often conspicuous in defence.

Team.—T. M. Body (back); S. Mason, C. Dix, T. A. Mayo, J. M. Plews (three-quarters); A. W. Nuthall, A. Ll. Vaughan (halves); W. F. Bennett, A. J. W. Wells, C. H. D. Robbs, A. M. Amsler, M. B. Scott, A. O'Neill, J. A. West, F. H. Noke (forwards).

ST. BART.'S v. R.M.C.

On Saturday, November 13th, at Sandhurst. The home team had a very heavy lot of forwards, and beat us by a goal and 3 tries (14 points) to *nil*.

The first half was well contested, R.M.C. scoring only 1 try, but afterwards our play fell off, and the defence was decidedly weak.

Body was unable to play owing to an injury, and Dix had to take his place at back; the three-quarter line was consequently somewhat disorganised.

Team.—C. Dix (back); S. Mason, T. A. Mayo, G. C. Marrack, J. M. Plews (three-quarters); H. Walker, A. W. Nuthall (halves); W. F. Bennett (capt.); A. J. W. Wells, C. H. D. Robbs, A. M. Amsler, M. B. Scott, A. O'Neill, J. A. West, N. Maclaren.

ST. BART.'S v. MARLBOROUGH NOMADS.

Saturday, November 20th, at Stamford Bridge. Playing with a weakened team, we were no match for the Nomads, who beat us by 2 goals, a dropped goal, and 2 tries (20 points) to *nil*.

We held our own fairly well in the "scrum," but when once the ball was loose our weakness was apparent.

The two halves and Bennett and O'Neill played best for us in a very disappointing game.

Team.—C. Dix (back); T. A. Mayo, J. C. Sale, J. M. Plews,

C. A. S. Ridout (three-quarters); H. Walker, W. C. Hirst (halves); W. F. Bennett, A. J. W. Wells, C. H. D. Robbs, A. M. Amsler, H. B. Scott, A. O'Neill, J. A. West, N. Maclaren.

ST. BART.'S v. CROYDON.

On November 27th, at Croydon. The home team beat us by a goal, a penalty goal, and a try (11 points) to *nil*.

We were very unlucky to be beaten by so much, as we had quite as much of the game as our opponents, and had bad luck in not scoring. We went off with a good dash, and pressed hard for some time. The home team managed to clear their lines, and worked the ball down, and kicked a penalty goal for which off-side play was responsible. Directly afterwards Croydon got another goal from a try. After half-time our outsiders were conspicuous for some excellent runs, both Mayo and Mason nearly scoring, and the forwards made some excellent dribbles. Croydon scored once more, after an excellent run by one of their three-quarters.

ST. BART.'S v. OLD LEYSIANS.

December 4th, at Stamford Bridge. After a succession of defeats we managed to win this match by the wide margin of 4 goals 2 tries (26 points) to 1 try. Directly after the kick-off Bennett dribbled down to the line, and passed to Robbs, who easily scored. Shortly afterwards Dix intercepted a pass and transferred to Mayo, who after a good run scored between the posts. We scored twice more in the first half through Wells, who made two excellent runs. The O.L.'s back received a nasty kick, but pluckily continued to play.

In the second half we had nearly all the game, and scored twice more through O'Neill and Robbs. O'Neill converted 3 tries, and Mason converted 1. The form displayed by the whole team was excellent. The passing was particularly good. The Old Leysians were not at full strength, and were never dangerous except when they scored their try by a good forward dribble.

Team.—C. A. S. Ridout (back); S. Mason, C. Dix, T. A. Mayo, J. M. Plews (three-quarters); H. Walker, W. C. Hirst (halves); W. F. Bennett, A. J. W. Wells, C. H. D. Robbs, A. M. Amsler, M. B. Scott, A. O'Neill, J. A. West, N. Maclaren.

ST. BART.'S v. OLD MERCHANT TAYLORS.

December 11th, at Richmond. This match after a close game resulted in favour of the O.M.T.'s by 1 try to *nil*. During the first half the game fluctuated considerably, both lines being invaded, but at half-time there was no score. Shortly after the resumption the Taylors scored a rather lucky try. This roused us, and we very nearly equalised, Dix being pushed into touch at the crucial moment. Nothing further was done.

Team.—C. A. S. Ridout (back); S. Mason, C. Dix, T. A. Mayo, J. M. Plews (three-quarters); H. Walker, W. C. Hirst (halves); W. F. Bennett, A. J. W. Wells, C. H. D. Robbs, A. M. Amsler, M. B. Scott, A. O'Neill, J. A. West, N. Maclaren.

ST. BART.'S v. UPPER CLAPTON.

December 18th. This match had to be abandoned owing to a dense fog.

ASSOCIATION FOOTBALL CLUB.

ST. BART.'S v. CIVIL SERVICE.

Played at Chiswick Park on November 20th. Result, a win for Bart.'s by 3 goals to 2.

This was a very creditable performance on the part of the Hospital, as Talbot did not turn up at all, and Marrett was *hors de combat* in the second half, so practically the Hospital played with three forwards, and each of these three, Whitaker, Willett, and Hughes, scored a goal in the second half.

Civil Service went off with a rush, and had the best of matters for the first quarter of an hour, scoring their first goal in that time. Then Bart.'s settled down, and though they played fairly well together they did not score, although Whitaker had hard luck on one occasion when he put in a clever fast shot. In the second half the passing improved and Whitaker equalised; but later on Civil Service got the lead again; Bart.'s were then fairly on their mettle, and in the last quarter of an hour scored twice more, thus leaving the field with a well-deserved victory.

Butcher kept goal well, and Stone made a good show in his first appearance as a back. All the halves worked well; their passing is improving, being not so hard, and more along the ground. The play of the three forwards mentioned above was excellent, and Marrett, while fit, played a dashing game.

Team.—H. H. Butcher (goal); G. W. Stone, L. Orton (backs); E. H. Scholefield, C. G. Watson, A. H. Bostock (half-backs); J. A. Willett, L. E. Whitaker, L. E. Hughes, H. N. Marrett (forwards).

On November 24th the Casuals were unable to bring a team, so their match was scratched.

LONDON SENIOR CUP TIE.

ST. BART.'S v. BARNET.

On November 27th at High Barnet. Result, defeat by 4 goals to *nil*.

The first half-time, though Barnet had the best of it, St. Bart.'s managed to keep the home team out; thanks chiefly to some splendid "saves" by Butcher, and good work by the backs and halves.

Stone got away once for the Hospital, but shot over; this was hard luck, and due to the long grass and the downhill nature of the ground, as he was going at a tremendous pace.

In the second half Barnet gradually asserted their superiority, and soon scored a goal. An odd decision of a penalty by the referee soon gave them another. After that in the failing light Barnet added two more, Bart.'s not knowing the ground well enough.

Several factors combined against Bart.'s and caused their defeat. The ground was as bad as could be wished, and the gale of wind made matters worse. The Barnet team did not play the game that Bart.'s are accustomed to; hence the disappointing game and result. There is one bright spot, however, and that is the magnificent display of Butcher in goal; he did many brilliant things, and made no mistake. Orton at back was also very sound. *Teams:*

St. Bart.'s.—H. H. Butcher (goal); L. Orton, C. H. Turner, E. H. Scholefield, C. G. Watson, A. H. Bostock (half-backs); T. H. Talbot, J. A. Willett, L. E. Whitaker, G. W. Stone, H. N. Marrett (forwards).

Barnet.—C. W. Cloutte (goal); J. T. Easton, S. G. Slark (backs); A. Belcher, W. Kinsley, J. McCleod (half-backs); W. James, C. Langley, J. Prince, T. H. Edey, and P. Cocks (forwards).

ST. BART.'S v. TUNBRIDGE WELLS.

Played at Tunbridge Wells on December 4th. Tunbridge Wells were without Wilson and Wace, while Willett, Talbot, and Bostock were absent from the Hospital team.

Whitaker won the toss, and after a few minutes Hughes had hard luck in not scoring with a hot shot that hit the bar. Tunbridge Wells then had a turn, and though Butcher saved from B. Murdoch, Toss will open the score for our opponents.

Bart.'s played up hard, and Stone and Whitaker scored, putting Bart.'s ahead. Before half-time, however, C. Murdoch had made matters equal. On restarting give-and-take play ensued, a *melee* in front of the Hospital goal resulting in one of the Bart.'s side heading the ball into his own goal, giving the Wells a lead of 3-2. Bart.'s did not allow this state of affairs long, and Stone soon equalised. The rest of the game was fast and exciting, but as the shooting fell off neither side could score, leaving the result a draw of 3 goals all—which fairly represented the game. V. G. Ward made a very good appearance in the Hospital team.

St. Bart.'s.—H. H. Butcher (goal); L. Orton, C. H. Turner (backs); E. H. Scholefield, C. G. Watson, R. Aldersmith (half-backs); V. G. Ward, G. W. Stone, L. E. Whitaker, L. E. Hughes, H. N. Marrett (forwards).

Tunbridge Wells.—R. H. Jones (goal); H. A. Barton and S. Lambert; J. Cowan, A. Macdonald, S. S. Weekes, B. Murdoch, C. Murdoch, F. S. Toss will, H. N. Haslam, and M. Nash.

The match *v.* Sittingbourne that should have been played December 8th has been postponed till March 9th.

ST. BART.'S v. NEWBURY.

December 11th, lost 2-4.

St. Bart.'s were very weakly represented, no less than five of the team being away; and to make matters worse Willett, owing to a mistake, did not turn up, a local substitute taking his place.

Bart.'s won the toss, and started with the wind; though Newbury pressed, Marrett soon broke away, and from a good run and centre Whitaker scored the first goal for the Hospital.

Play continued level, and shortly before the interval Whitaker intercepted a pass between the Newbury backs, and going right through, scored a second goal for Bart.'s. Although in this half Newbury pressed a good deal, Body safely negotiated their shots.

From the re-start Newbury went away, and soon scored their first goal, which was quickly followed by a second. More even play followed, and Whitaker on two occasions only just missed scoring;

but his efforts were not backed up, as Murdoch on the inside left had strained his leg early in the game.

A mistake by Orton resulted in a third goal for Newbury, and just on time their inside right added another.

Considering the strength—or rather the weakness—of our team, the result might have been much worse, and all the team played up well. Whitaker played splendidly at centre, and Marrett was good; of the back division Scholefield, Waterfield, and Orton bore the brunt of the work.

Team.—T. M. Body (goal); L. Orton and C. H. Turner (backs); R. Scholefield, C. G. Watson, and R. Waterfield (half-backs); A. S. Woodward, L. E. Whitaker, C. Murdoch, H. N. Marrett, and A. Substitute (forwards).

The match *v.* Pemberton, at Winchmore Hill for Saturday, December 18th, had to be scratched, as the Hospital could not raise a team.

The draw for the Inter-Hospital Cup first round is as follows:

Charing Cross.....	<i>v.</i>	Guy's.
London	<i>v.</i>	Middlesex.
St. Mary's	<i>v.</i>	St. Bart's.
St. Thomas's	<i>v.</i>	University.

Abernethian Society.



MEETING of the above Society was held on Thursday, December 18th, 1897, Mr. Horder, Vice-President, in the Chair. Mr. Paterson gave a demonstration of the apparatus used in his administration of gas and oxygen. He held that with this a patient could be kept anaesthetised for half an hour and over, with a minimum of danger and practically no distress to the patient; another advantage claimed being that there were very few of the after effects which are so common in ether and chloroform; if a patient were sick at all after the administration, he rarely was so more than once.

The Vice-President then introduced Mr. Wallis, and said how pleased the Society was to welcome him back into its midst again.

Mr. Wallis, after a few preliminary remarks about the pleasure it afforded him to be back once again in "the old Abernethian vaults," and the happy times that he had spent there, read a paper entitled "Some Points in the Diagnosis and Treatment of Pott's Disease of the Spine." He pointed out how that very frequently the very first symptoms of Pott's disease were mistaken for ordinary lateral curvature, and treated accordingly, the result being disastrous to the welfare of the patient. Two cases of this description were cited.

Then, how great a necessity there is for clearly distinguishing between hip and spinal disease; and this is most likely to occur when the lumbar spine is affected.

With regard to treatment:

Aspiration.—Aspiration with injection of iodoform emulsion and opening and draining, the speaker did not regard as good treatment, except in special circumstances. Mr. Treves' operation of an opening in the loin he did not adopt, because in the first place he considered the abscess very difficult to find that way, there being so little room, and also

because of the rarity of the presence of a sequestrum, for which this operation was originally performed. The method recommended is as follows:

The skin being scrupulously prepared, the abscess is opened above Poupart's ligament by an oblique incision, avoiding the peritoneum; and a counter opening made in the loin by cutting on a pair of curved forceps introduced through the abdominal incision. The sac is thoroughly scraped with a Volkmann's spoon, mopped out with cotton wool, and flushed with 1 in 2000 perchloride. Then a preparation of iodoform paste made by mixing the powder with 5 per cent. solution of carbolic acid is rubbed into the sac wall. The anterior incision is then closed by a continuous suture, and smeared over with iodoform paste, followed by collodion. A long strip of iodoform gauze is pushed into the lumbar wound to act as a pack and drain for about twenty-four hours; it is then removed and the wound sewn up. This treatment Mr. Wallis has adopted for some time, and found it answer extremely well.

The Rahere Lodge, No. 2546.



AN Ordinary Meeting of the Rahere Lodge was held at Frascati's Restaurant, Oxford Street, W., on Tuesday, December 14th, 1897, Bro. W. G. Walsham, W.M., in the chair.

Bros. Hampton and Miles were raised to the third degree in Freemasonry by the W.M. Bros. Auden, Marshall, Bill, Cripps-Lawrence, Adams, Westbrook, Trechmann, and Surgeon Folliott, R.N., were passed to the second degree by W. Bro. Gilbertson. Dr. J. B. Christopherson was elected a member of the Lodge, and was afterwards initiated into the mysteries and privileges of Ancient Freemasonry by W. Bro. E. C. Cripps. Bro. Arnold W. Izard, of the Isaac Newton University Lodge, No. 859, was elected a joining member.

The W.M. Bro. Walsham was appointed to represent the Lodge at the forthcoming Centenary Festival of the Royal Masonic Institution for Boys, and W. Bro. Ashton Godwin offered to serve as a steward on the same occasion. The Lodge granted a sum of £21 to the British Medical Benevolent Fund, and afterwards appointed as the trustees of its own Funds W. Bro. Clement Godson, W. Bro. Gripper, Bro. the Rev. Sir Borradaile Savory, Bart., and Bro. W. H. Cross.

The members of the Lodge with their guests afterwards dined together, to the number of forty. The evening was enlivened with unusually good music; the singing of Bros. Cripps, McCann, and Valérie, and the pianoforte and violin recitations of W. Bro. Burns and Bro. Trechmann receiving especial applause.

Dinner to Dr. W. J. Collins.



HE Complimentary Dinner to Dr. Collins, given on December 16th at the Trocadero, was a great success in every way. Mr. Marsh was in the chair, and no less than 128 old Bart.'s men assembled in honour of the guest of the evening, amongst them being Sir R. Craven (Hull), Mr. Henry

Power, Mr. Willett, Sir Richard Thorne Thorne, Dr. Griffith, Mr. Bowlby, Mr. Lockwood, Dr. Claye Shaw, Mr. Jessop, Mr. Berry, Mr. D'Arcy Power, Dr. Shore, Dr. Calvert, Mr. Womack, Mr. Waring, Mr. Leonard Mark, Dr. Robert Jones (Claybury Asylum), and Mr. Reginald Harrison. Letters expressing regret at being unable to be present were received from Dr. Church, Mr. Vernon, Dr. West, Dr. Alexander Hill (Cambridge), Mr. Barling (Birmingham), Surgeon-Captain Rayner, and others.

The dinner was good, and the band played an excellent selection. Mr. Marsh's genial spirit infected the whole company, and everyone thoroughly enjoyed themselves. Mr. Leonard Mark had designed a most appropriate and much admired menu card, the framed original for which, together with an album containing the names of those present, was presented to Dr. Collins during the evening. The Secretaries were Mr. Bruce Clarke, Mr. R. W. Lloyd, and Mr. Ernest Clarke, to whose energetic organisation all who were present are indebted.

After dinner Mr. Marsh rose, amid cheers, and said: "I have now to propose the health of our guest this evening, Dr. Collins, formerly a student of our medical school, and now chairman of the L.C.C. This is the toast of the evening, but I shall extend its range and term it also the toast of the Medical School of St. Bartholomew's Hospital and of the L.C.C. itself. It is obviously the toast of the evening, for it is the very thing we have come here to drink in bumpers. It is in a certain sense the toast of our Medical School, for amongst the men who have been distinguished there Dr. Collins has achieved a highly distinguished, and in fact a remarkable position. And I will call it the toast of the L.C.C. The L.C.C. is a somewhat heterogeneous body, composed of a number of groups that can very seldom be unanimous. The Council would not be unanimous, I suspect, if the question were what changes should be made in the arrangement and method and working of the Solar System; or, again, what course should be pursued in relation to Mrs. Ormiston Chant and her propaganda. But I believe there is one thing that would bring these different groups into complete harmony, and that would be an opportunity of drinking Dr. Collins's health, and acknowledging the heavy debt of gratitude under which he has laid the Council by the services he has rendered them as their Chairman.

"It seems obvious that so large and divided a body as the L.C.C. could do no useful work at all except under the guidance of a strong chairman, and as to what sort of a chairman Dr. Collins has been I have some information which I will give you presently.

"We all remember Dr. Collins as one of the most brilliant students we have ever had at St. Bartholomew's Hospital, and how he cut the record at the University of London. But it is not enough that a man should take a hatful of prizes. Many can do this, and are good for nothing else. They are instances of irregular hypertrophy, with atrophy in other directions. But we all know that Job Collins was not a man of this kind. His performances in what I will call the prize ring, where he was such a notable bruiser, were only on a level with his other achievements, and an index of his general mental equipment. Now in what a striking manner has this medical diagnosis (and medical diagnoses have not always turned out to be correct) been confirmed by Dr. Collins's work in the wider arena in which he is at present occupied.

"The position he has achieved I may term without any exaggeration a really remarkable one. Only a few years ago he was merely a medical student with no connection with, or specially favorable introduction to public life. Now he is one of some six or seven men who occupy the most important and the most responsible positions in the largest, the richest, the most complex and the most powerful city that the world has ever seen; and let me remind you that Dr. Collins has attained this position although he is only just thirty-eight.

"Now, such immortals as Byron, Keats, and Shelley attained, or shall I say disclosed their immortality, before they were thirty; but these and their compeers must be left in a group by themselves; when, however, we come down from the immortals to men who are only remarkable, what do we find? Pitt was Prime Minister before he was twenty-four, but he had exceptional advantages, and circum-

stances were altogether in his favour. Now, setting him aside and keeping to the present century, I do not remember anyone who has reached such a position at his age, and considering his antecedents, as that which Dr. Collins now occupies.

"But now let me ask how he has discharged the duties of his office? As chairman of the L.C.C. is he a failure, or is he a success? Must we regard him as the fly in amber, and "wonder how the devil he got there?" Well, I have some information as to the manner in which he has acquitted himself, and this comes not from his own side, but from those who, if they could, would have prevented his election; and more than that, it comes from three men who occupy a high position in the Council. One told me that Dr. Collins was a very able chairman, level-headed, a thorough master of the constitution and working of the Council, dignified, judicious, and judicial. Another said that he was, in his opinion, the best chairman they had ever had, not excepting Lord Rosebery. A third—and this seemed to me the strongest praise of all—that Dr. Collins had done what he could to discredit the influence of party spirit in the Council, and to secure the consideration of the different questions that were brought forward on their merits, instead of on the lines of party politics.

"There are three chief types of men who are concerned in the affairs of a state. The first, who is devoured by personal ambition and a desire to make himself a master of the world, and who is by no means scrupulous as to the measures he adopts—such was Julius Cæsar. Well, let us congratulate Dr. Collins and ourselves that he is not a new Julius Cæsar. Then there is the man who, however splendid his abilities, sees affairs in so many aspects that he is unable to concentrate his efforts on a single line of action, and thus he fails. Cicero well illustrates this type. From this point of view our guest is no Cicero. But yet in another aspect, that is in regard to his oratory, there is much of the Cicero in him. The third type is that of the man who makes his own personal advancement and everything else subservient to the welfare of the state. This type is represented by Cato. Now let us remember that Cato was the only one of these three who died in his bed. He reached a ripe old age, and at the end of it was able to say that he only regretted three things; first, that he had once gone by water when he might have travelled by land; the second, that he had spent an idle day; the third, that he had told a secret to his wife. And Cicero held him in such regard that he introduced him as his main character in his treatise *De Senectute*. Well, from what I have said there is reason to believe that Dr. Collins will become a second Cato. Let us, therefore, very heartily drink to the health of Cicero, Cato, Collins—names the initials of which, I am reminded by Dr. Godson, correspond with the two C's in the title of the body over which he presides. Let me remind him that this meeting is a meeting of those who know him best, and are therefore best qualified to judge of his character and work. I will ask him to accept this album containing the names of those who are here this evening, and also this design by his old friend Leonard Mark,—which represents on the one hand the Chairman of the County Council on his judgment seat, and on the other a view of St. Bartholomew's Hospital; and let me hope, Dr. Collins, that as you look around you upon this scene and on this company, and as you glance at these small presents, we may anticipate that "*forsan et hæc olim meminisse juvabit*."

Dr. Collins then said, "Mr. Marsh and gentlemen, one would indeed be a numskull and a heartless person if one were not profoundly touched by this expression of your good-will. The whole conception of this dinner, the sketch by Mr. Mark, the way in which it has been organised, the kind words spoken by yourself, and the way this toast has been received, almost overwhelm me. I might well remain silent, as I can hardly find adequate language in which to express my feelings. Presiding at the London County Council, so far from encouraging oratory, tends to suppress it. I found the Abernethian Society a far more suitable atmosphere for the practice of oratory. At the London County Council the fifteen minutes rule tends to discourage eloquence; it suffices for remarks, but scarcely allows the delivery of speeches: moreover, the exigencies of office have during this year prevented me from taking part in the debates. Well, Mr. Marsh, I must at once discount the too generous praise in which you have indulged; I must attribute these classical references to your superabundant generosity, and when I have subtracted from your words such epithets as are due to this cause, I am still compelled to conclude that the charge of megalomania made against the County Council must include other persons as well; further, I must add that my friend Dr. Claye Shaw has evidently not the complete control of those people who entertain large delusions in reference to the capacities of their fellows.

"Gentlemen, I find great difficulty in knowing what I am to say on this occasion, being in a sense the objective of this banquet. I must

not talk shop; that would ill requite your hospitality. I must not talk politics; Mr. Henry Clarke, representing the side to which when not in office I have not the honour to belong, is present, and would very properly resent such reference. I can hardly talk about myself; that would be a very unengaging topic, and practically everyone in this room has known me for more than half my life. I asked myself as I was coming here to-night, however it was I came to be connected with St. Bartholomew's Hospital at all. I went to University College School; the site of that edifice was formerly the receptacle of the dead dogs and cats of London, and rejoiced in the appellation of "Stinkomalee;" on that site arose the now famous school, whose object was to give the rudiments of liberal education to Jews, Turks, infidels, and heretics. If its atmosphere was somewhat liberal and progressive, on the other hand that of St. Bartholomew's is perhaps somewhat conservative and moderate; but, sir, I shall ever look back upon that decade of student, resident, and teacher life at St. Bart.'s as perhaps the happiest years I can remember. It is associated with undying memories of friendships. I also was brought in contact with city life, that life of which Mr. Henry Clarke is so worthy a representative; "the old city," as it is irreverently termed in a Royal Commission, became known to me, and its history was traced out in my daily walks in the old walls, and gates, and churches, and the historic memories of Smithfield. No one acquainted with these old buildings about St. Bart.'s could fail to wish that even in the hurly-burly of politics no irreverent hand should lightly hurl the contumelious stone against a body which in its day withstood kings, princes, and barons, and in the darkest days of English history stood out for enlightenment, liberty, and progress.

"Many of us here remember October 1st, 1876. Very green and fresh we were, and when we found ourselves at St. Bart.'s we must have felt indeed like the flies in amber. Well, sir, if I had to determine what it was that finally induced me to enter St. Bart.'s, I should have to attribute it to the seductive fascination of the then Warden of the School. I had not a single friend in the place; the first man I spoke to, or rather who spoke to me, was Hockin, 'whose romantic courtship, marriage, and untimely death far from these shores is known to all. "I believe we have to walk the Hospital," he said to me, and we forthwith peeped into one of the wards, but the black looks of the Sister, who pursued us like a Gorgon, frightened us away, and that was our only experience of walking the Hospital for at least another two years. St. Bart.'s twenty-one years ago was very different to what it is now. Sir James Paget, I believe, once lectured on St. Bartholomew's Hospital fifty years ago; great changes have taken place even since 1876, which we recall vividly. The old room of the Abernethian Society is gone; the Society for a while occupied a temporary iron shed called the "kettle," where I remember many speeches and debates, and where the subsequent refreshment was served by Mr. Pickering. There was to me always somewhat of a pathological flavour about the tea, probably owing to the manner in which that worthy official was engaged during the earlier part of the day. It is not for me to fight again those old Homeric battles. I will, however, take some credit for one thing; it was proposed that the nurses should be allowed to attend some of the meetings of the Abernethian Society; this was looked upon as revolutionary, and the first time it was mooted I was the only one who voted for it, I believe. It has now, however, become a well-established, and I understand a very successful custom, Matron and nurses attending in all their glory; apparently in this instance, at any rate, I was a reformer in advance of his time. Mr. Bruce Clarke I remember well as house surgeon, and I owe much to his encouragement; he was always most kind to me, and seemed to have a regard for me quite out of proportion to the facts of the case. Many of those with us then have now passed away; I must mention one of them—one to whom I owe a great deal—my old chief James Matthews Duncan. The fiery rectitude and the wholesome scepticism which he brought to bear on his work were, I venture to say, very valuable additions to St. Bart.'s.

"Well, Mr. Chairman, I have heard it said outside that it is unwise for a medical man to mix in public life; I do not think this is so, at any rate as regards the kind of work performed by the body over which I have the honour to preside; it is largely concerned, as you know, in ministering to the public health. In the latter part of the last century the chief political considerations seem to have been in regard to the "wealth of nations;" at the end of this century, I venture to think, our politicians are as much if not more concerned with the "health of nations." I cannot help thinking that the participation of medical men in municipal administration is most valuable, and that doctors are at least as great a necessity there as any other profession,

"A wise physician skilled our wounds to heal,
Is more than armies to the public weal;"

and I, at any rate, maintain that in administrative public work, medical men are greatly needed. What are some of the duties that the London County Council has to perform? We have to deal with sewage, and to dispose of 78,000,000 gallons from more than 4,000,000 persons; we have to deal with the housing of the poor, a branch of work in which Dr. Young and Dr. Hamer, who are here to-night—both of them Bartholomew's men—have rendered valuable services; then we have 1300 lunatics under our control, and Bart's has helped us again in this respect by giving us Dr. Claye Shaw and Dr. Robert Jones, who are among the great authorities in alienist medicine; then we have the water-supply, the regulation of coroners' duties, in all of which medical knowledge is involved or at least desirable. But I go further, sir, and I claim that the training of medical men should specially qualify them for the public service. Why should other professions have the monopoly of it? In France the engineers take an active part. What is the difference between a surgeon and an engineer? The surgeon operates on man, and the engineer operates on nature. Why should public work be so much given up to the lawyers? Why have they such a disproportionate representation? I claim that a medical training marks men for a public life. For what is diagnosis in its ultimate analysis but the prompt apprehension of minute differences? What is prognosis but judgment in provision based upon accurate past experience; and what is treatment in its final essence but resourcefulness in case of emergency,—all qualities I maintain in the highest degree valuable in public life. As for myself, I hope it is unnecessary before this audience to plead an apology for my life; to those who put forward the myth that my public duties have made me give up my profession, of which I am proud, I would say that I utterly repudiate any such notion. Many of us have grateful recollections of Mr. Marsh's lectures on practical surgery, and even to-day I took down my note-book and read again some of his well-remembered tips, with which he literally covered the body from top to bottom; he began with Pott's puffy swelling, and concluded with the fundamental distinctions between blind internal and external fistulae. Lastly, let me say that it was no desire of mine that ended my career at St. Bartholomew's Hospital. I completed my period of two years as assistant demonstrator of anatomy, and my application to serve for another year was refused. The result was conveyed to me by Mr. Willett, and this he did in so delicate a manner that I verily believe I should have been satisfied under his genial kindness and direction even if I had been led to execution or to the stake. My first experience in residence as house surgeon was under Mr. Henry Power, and I have the most grateful recollection of his exemplary courtesy and kindness. That year in residence was a delightful one, though the delight did not exactly arise out of the quarters in which we lived. The arrangements were somewhat odd; into the room where I lived as midwifery assistant the light of heaven was never capable of entering, and at night I was lulled to sleep by the discordant noises of Smithfield Market carts.

"In those days, however, I learnt the geography of the city, and my experience in going about to cases of placenta prævia stood me in good stead the other day at the Cripplegate fire, as it enabled me to thread my way with the Chairman of the Fire Brigade Committee to the spot.

"Mr. Marsh and gentlemen, I am afraid I am indulging in rather egotistical recollections, with which I promised at the outset not to bore you, so I will draw my remarks to a close. I am profoundly grateful for your hospitality, and I can only say that while in my work as Chairman of the London County Council, a post of importance and responsibility unsurpassed by any of the kind in the kingdom, I have often felt the anxieties well-nigh overwhelming, I have been and shall be greatly supported and inspired by evidences such as those I have received to-night, and which seem to indicate that I retain the esteem of my professional brethren.

"The sketch so kindly made by Mr. Leonard Mark, and the album of autographs you have handed to me, will remain with me among my most precious possessions as long as life lasts."

We regret that lack of space prevents our reporting the other speeches in full.

Sir R. Thorne Thorne proposed the health of the Chairman in a felicitous speech, and Mr. Marsh responded. Mr. Willett then proposed the toast of the Honorary Secretaries.

Mr. Bruce Clarke, Mr. Ernest Clarke, and Mr. Lloyd each replied in suitable terms, and thus a highly successful evening was brought to a close.

Christmas in the Wards.



A GREAT deal of energy and originality was displayed over the Christmas celebrations in the wards this year.

The decorations everywhere were quite up to their usual standard—fairy lights, Chinese lanterns, and ivy trails forming the most salient features. In one or two wards notably, Paget and Martha, a less distinctively Christmas, though undoubtedly elegant character was achieved by graceful draperies and colour schemes.

Though the time-honoured Christmas tree was represented on a sumptuous scale in Faith and Lucas, a new departure was successfully carried out in Elizabeth and Paget, in the form of erections purporting to be fancy fairs or stalls, on which presents for the patients were arranged, and a mimic sale was conducted in a spirited manner by the respective Sisters.

In Luke a very effective animal, natural order vague, but representing impartially a Polar bear or a lamb, was filled with presents, and led round the ward on wheels to the delight of the patients.

In Darker yet another new departure was to be met with. The old-fashioned bran-pie was superseded here by the counterfeit presentment of a real pie with crust, the presents coming out of a hole in the top. Placed on a table with a real table-cloth, knife, fork, and spoon, the illusion was complete. "A slice of Sister's bran-pie" was in great demand by the patients throughout the evening.

Presents of warm clothing and useful things were mostly distributed early in the day, leaving the rest of the day free for the various entertainments.

A reasonable spirit of pantomime seemed to have taken possession of the "Entertainment Committee" this year: Stanley boasted a very pretty little boy dressed as a Pierrot; in Elizabeth two tiny gauzy-winged fairies representing holly and mistletoe flitted about in great enjoyment of the bright scene, and certainly well deserved the admiration bestowed on them. Sweets were distributed by a little "Japanese lady," who in a real "kimono" looked remarkably quaint and picturesque.

Extremely amusing and carried out with much skill were the "monkey" and the "donkey," the latter drawing a cart containing presents for Sitwell patients; much admiration was excited by their simian and asinine antics, performed with untiring energy and good nature, under somewhat trying conditions probably.

Music, professional and amateur, was varied and much appreciated everywhere, but of the latter first place must without doubt be given to the twelve "doughtie men" who performed in the "Bigophone" band, and "played" in such an exhilarating style to most varied audiences.

Some charming glees were given by Messrs. Drury, Hussey, Douglas, and S. F. Smith; the latter accompanying on the banjo. As with the bigophone, each ward where they sang would have gladly retained their services for the whole evening.

A Pierrot and Pierrette troupe, consisting of Messrs. Grace, Horder, Coleman, Dyer, Walker, Miss Pritchard and Miss Coleman, played and sang, and provided a delightfully novel entertainment to both eye and ear. Their "get up" was particularly successful.

A professional quartette of glee singers most kindly gave their services towards the amusement of the patients, and needless to say were greatly applauded. Other entertainments, *e.g.* a phonograph, magic lanterns, conjuring, fish-ponds, &c., were all much enjoyed by the patients, and helped once more to make Christmas Day in the Hospital a thoroughly happy one.

The Christmas Entertainment.



THOSE who were responsible for the Annual Performance are to be heartily congratulated on the very excellent entertainment they provided last week. We should be inclined to criticise the choice of the second piece—"Weak Woman"—for a performance of this sort, as the play depends so much for its effect on the female interest, which makes it a very bold one for men to attempt. However, having been chosen, we have nothing but praise for the performance.

The evening began—after the overture to "Rosamunde" had been played by the Hospital orchestra—with "The Duchess of Bayswater and Co." which went exceedingly well on the whole.

The very amusing part of Sir Jeremy Joles was in the safe hands of Mr. Brownlow, who, although he undertook the part at short notice, succeeded in giving a most admirable and humorous interpretation of the character; his appearance and make-up were most effective, and he made his many points with the greatest success. Mr. Hobday, as the trade-smitten Duke, played excellently, although it was a little difficult to hear him from the back of the hall. His matter-of-fact proposal was especially funny. Mr. Tweedie, both in this piece and in "Weak Woman," kept up a most trying falsetto voice with really commendable energy and success. Of the rest Mr. Meakin was responsible for Caryl Stubbs, and, though a little cold in his love-making, acted very well. Mr. Hawes made a very stately and effective Jenkins, and Mr. Slade looked admirable as Kathleen. The play generally went with a smoothness and vigour that reflected the greatest credit on the stage management and coaching.

The second part began with two glees—"Gipsy Life" and "Three Doughtie Men"—by the Hospital Choral Society, who, in spite of a most uncomfortable crowding on the small stage, sang with vigour and accuracy. Our thanks are due to Nurse Carson, who accompanied on Thursday night at very short notice, owing to the unpardonable absence of the accompanist. On this evening Mr. S. F. Smith sang "A May Morning" very well, and Nurse Ball charmed us again with "Butterflies," for which she gained a well-merited encore. On Friday the feature of the evening was the singing of Madame Giulia Ravogli. She most kindly sang four songs in response to repeated demands; one each from "Faust," "Carmen," and "Lucrezia Borgia" respectively, and "Kathleen Mavourneen," and it is hard to say which was the most delightful. Mr. P. Wood presented her with a bouquet on behalf of the Musical Society. His own singing of "The Golden Vanity" calls for the highest praise; and this we give in saying that he excelled all his previous efforts.

The third part followed a brief interval for refreshments. The Dramatic Society came out triumphant from the ordeal of playing "Weak Woman." The play opened in a most charming out-of-door scene, in which we are introduced to two supposed heiresses—Helen and Lilian Gaythorne—who labour under the disadvantage of an unknown will. The various adventures of the several suitors for the hand and fortune of the fortunate owner of the property furnishes the motive of the comedy. Mr. Whitaker as Arthur Medwyn, a gentleman farmer, opened the play, and was successful throughout, though he had, perhaps, a tendency to underact the part. Mr. Meade made an excellent character of the fatuous Tootal, and Mr. Gibson played the Doctor with becoming decorum and dignity. The very difficult parts of the two young ladies were taken respectively by Mr. Slade and Mr. Grenfell, and they are to be heartily congratulated on their appearance and performance. Mr. Slade was especially good, acting throughout with ease and humour. Mr. Grenfell was inclined to be too stiff and monotonous, but his appearance was most successful. Mr. Tweedie was again excellent as the impressionable Mrs. Gunn; his management of the various mysteries of the female costume was most skilful, and his disposition of his skirt on sitting down a liberal education to the ordinary male spectator. Mr. Everington was very much in earnest as Frederick Fanshaw; his scene with Mr. Grenfell was especially good. Much of the fun of the play is given to the part of Captain Ginger, and Mr. Valerie, in a splendid make-up and an entirely new voice, succeeded in keeping the house in a continuous roar of laughter. He played splendidly throughout the piece, making his many points with a certainty and ease that were most delightful to witness. His entrance in his new uniform and the succeeding love scene with Mrs. Gunn were really splendid; considering, too, that he had had all the trouble and anxiety of stage-managing, his performance was a really remarkable one, and he fully deserved the applause he gained. A word of especial praise must be given to the scenery, which was charming in both pieces. Between the acts the Hospital orchestra played various well-chosen pieces, under the capable direction of Mr. Pollard, which added much to the pleasure of the evening.

New Productions.

"SOLOID" COMPRESSED DRUGS FOR GYNÆCOPATHIC USE. (London, Burroughs, Wellcome and Co.)—Of the convenience and utility of compressed drugs we are being constantly reminded by the efforts of Messrs. Burroughs and Wellcome to meet the requirements of both physician and patient. Almost every practitioner must be aware by now of the value of their "emergency case" from practical experience. And now they have prepared a series of

"soloids" for the instantaneous preparation of irrigations, which should be of considerable convenience. The formulæ are as follows:—(a) the most sedative preparation consists of sodium bichlorate 20 grs., tincture of opium 10 minims—one to four soloids to be dissolved in a pint of water; (b) both sedative and astringent—zinc sulphate 5 grs., lead acetate 10 grains, extract of opium 2 grs., tannin 1 gr.—one or more to be dissolved in sufficient warm water; (c) astringent—zinc sulphate 15 grs., alum 15 grs.—two or four to be used to the pint of lukewarm water. The price is very reasonable, (a) and (c) being supplied to the profession at 8d. a bottle of 25, and (b) at 1s. 3d.

"TABLOID" CHEMICAL FOOD (PHOSPHATES COMPOUND) (London, Burroughs, Wellcome and Co.).—This seems a portable and convenient form of a well-established drug, which has the decided advantage over the other preparations in that it does not stain the teeth. We should doubt, however, if children would take them if they could not be induced to swallow fluid medicines. These "Tabloids" (a word, by the way, which is the property of Messrs. Burroughs and Wellcome) are sugar-coated, in two sizes, representing half and one drachm doses respectively.

The Month's Calendar.

[Secretaries of Clubs, &c., are requested to co-operate in making this list as complete as possible by forwarding notices of forthcoming events to the Editor.]

JANUARY, 1898.

- Sat. 15th.—A.F.C. v. Cheshunt, at Winchmore Hill. R.U.F.C. 2nd XV v. Guy's Hospital 2nd XV, at Winchmore Hill.
- Mon. 17th.—Preliminary Scientific and Intermediate M.B.(Lond.) Examinations begin.
- Tues. 18th.—Sir Dyce Duckworth's and Mr. Langton's duty.
- Wed. 19th.—Sir Thomas Smith's Clinical Lecture, 2.45 p.m. A.F.C. v. Clapham Rovers, at Winchmore Hill.
- Thurs. 20th.—Abernethian Society at 8 p.m. Dr. Milne Bramwell on "Hypnotism."
- Fri. 21st.—Dr. Hensley's and Mr. Marsh's duty. Dr. Gee's Clinical Lecture, 1 p.m.
- Sat. 22nd.—A.F.C. v. Barnes, at Winchmore Hill. A.F.C. Reserves v. Old Foresters.
- Mon. 24th.—Volunteer Medical Staff Corps (Bart.'s Company). Second Annual Ball at King's Hall, Holborn Restaurant, at 8.20 p.m.; Hon. Secs., J. C. S. Dunn and E. A. May.
- Tues. 25th.—Dr. Brunton's and Mr. Marsh's duty.
- Wed. 26th.—Mr. Butlin's Clinical Lecture, 2.45 p.m. R.U.F.C. 2nd XV v. University College School. A.F.C. v. Eastbourne, at Eastbourne. A.F.C. Reserves v. St. Mary's Hospital II.
- Thurs. 27th.—Abernethian Society, at 8 p.m. Dr. W. H. R. Rivers on "Fatigue."
- Fri. 28th.—Dr. Church's and Sir Thomas Smith's duty. Sir Dyce Duckworth's Clinical Lecture, 1 p.m.
- Sat. 29th.—A.F.C. v. Old Brightonians, at Winchmore Hill.

FEBRUARY.

- Tues. 1st.—Dr. Gee's and Mr. Willett's duty.
- Wed. 2nd.—Mr. Butlin's Clinical Lecture, 2.45 p.m. A.F.C. v. Casuals, at Tufnell Park. R.U.F.C. 2nd XV v. Merchant Taylors' School, at Willesden Green. A.F.C. Reserves v. Holloway Sanatorium.
- Thurs. 3rd.—Abernethian Society, at 8 p.m. Mr. Gladstone Clark on "Extra-uterine Gestation."
- Fri. 4th.—Sir Dyce Duckworth's and Mr. Langton's duty. Dr. Hensley's Clinical Lecture, 1 p.m.
- Sat. 5th.—A.F.C. v. Beckenham, at Winchmore Hill. R.U.F.C. 2nd XV v. St. Thomas's Hospital II, at Winchmore Hill. A.F.C. Reserves v. Beckenham II, at Beckenham.
- Tues. 8th.—Dr. Hensley's and Mr. Marsh's duty. Meeting of Rahere Lodge at Frascati's.
- Wed. 9th.—Mr. Langton's Clinical Lecture, 2.45 p.m. A.F.C. v. Royal Engineers, at Chatham. A.F.C. Reserves v. City of London School, at Winchmore Hill.
- Thurs. 10th.—Abernethian Society at 8 p.m. Discussions, Clinical and Pathological.

- Fri. 11th.—Dr. Brunton's and Mr. Butlin's duty. Dr. Brunton's Clinical Lecture, 1 p.m.
- Sat. 12th.—A.F.C. v. Reigate Priory, at Reigate. R.U.F.C. 2nd XV v. Marlborough Nomads II, at Surbiton. A.F.C. Reserves v. Crouch End II, at Winchmore Hill. Hockey v. Epsom College, at Epsom.
- Tues. 15th.—Dr. Church's and Sir Thomas Smith's duty.

Some Books by Bart.'s Men.*



UR Hospital has generally been able to hold its own in the output of medical literature. The present is no exception to the rule, and we propose to notice here a few of the books published lately by members of this Hospital.

The place of honour must be conceded to Dr. Lauder Brunton's work on *The Action of Medicines* (1). Though we can add nothing to the chorus of praise with which this book has been hailed by the press, it is not fitting that the JOURNAL of the Hospital, in which these lectures were delivered, should be silent. We shall not attempt to analyse their contents, as they must be familiar to many of our readers, but merely add our appreciations. The keynote of the book is struck in the preface, where Dr. Brunton tells us of the method he had in view. He thought of Solon's answer in regard the laws which he had given to the Athenians—"Are those the best laws you can frame?" said his questioner, "No," said Solon, "but they are the best laws that the Athenians can keep." Dr. Brunton could have, in fact he has, written a more learned treatise on the action of drugs, but it is hard to believe that any book on the subject could impress itself more vividly and permanently on the minds of those for whom it was written.

In a word, the great merit of this work lies in its suggestiveness. The student is made to think for himself, to regard drugs not as so many uninteresting substances in bottles and boxes which he must perforce remember before he can enter through the ivory gate of qualification, but rather as the weapons with which he will have to fight disease throughout his professional life. None of the facts here chronicled belong to that large class which the student looks forward to forgetting as soon as possible; full of practical guidance, each point is driven home by an anecdote culled from a large experience.

Some authors have the faculty of impressing their individuality on their work, and this is eminently true of the book before us; both by diction and diagrams we are constantly reminded of its origin. Dr. Brunton tell us that he has now lectured for twenty-seven years on Pharmacology and Therapeutics, which makes the freshness, interest, and buoyancy of these pages all the more impressive.

We had hoped to notice Mr. D'Arcy Power's *Life of Harvey* on this occasion; and we regret the accidental but unavoidable delay. We have, however, received a copy of this author's *Hunterian Lectures on Intussusception* (2), which bear evidence of much careful work and observation on the anatomy, histology, pathology, and treatment of a very important disease. Of the anatomical points, a new one to which he has called attention is that at birth the large and small intestines are of about the same diameter, but the former rapidly increases in width while the latter is increasing in length; it is easy to understand how just at this period irregular peristalsis is most likely to precipitate the smaller into the rapidly growing larger tube. An interesting histological point is that the stress of the disease falls on the submucous and circular muscular coats, leaving the longitudinal muscular and serous coats but little affected. As to pathology, valuable experimental evidence is adduced as to the effect of irritants (such as turpith mineral and purgatives) in producing a series of contractions separated by relaxed portions of intestine, while substances producing orderly contractions (such as

* (1) *The Action of Medicines*, by T. Lauder Brunton, M.D., D.Sc., LL.D., F.R.S. (Macmillan and Co., 1897; Price 10s. 6d.)

(2) *Some Points in the Anatomy, Pathology, and Surgery of Intussusception*, by D'Arcy Power, M.A., M.B., F.R.C.S. (London, The Rebmam Publishing Company, 1897; Price 4s.)

(3) *John Hunter, Man of Science and Surgeon*, by Stephen Paget. (London, T. Fisher Unwin; Price 3s. 6d.)

(4) *Ambroise Paré and his Times, 1510—1590*, by Stephen Paget. (O. P. Putnam's Sons, London and New York, 1897; Price 10s. 6d.)

(5) *Aneurysms of the Aorta*, by Oswald A. Browne, M.A., M.D. (London, H. K. Lewis, 1897; Price 2s. 6d.)

(6) *District Nursing on a Provident Basis*, by Jameson B. Hurry, M.D. (The Scientific Press, Limited, 1898.)

eserine or barium chloride) render intussusception impossible. As to treatment, Mr. Power sums up in favour of hydrostatic pressure with hot salt solution of not more than three feet, except in enteric cases or those with very acute symptoms; the fluid is to be allowed to remain in at least ten minutes. After two unsuccessful attempts, or after three recurrences following reductions, laparotomy must be performed. Should enterectomy be necessary, a button or bobbin is recommended for enteric invaginations, while Maunsell's operation appears to be best adapted for the cure of the ileo-cæcal and colocolic forms.

It is interesting to note that John Hunter's pathological material was so well preserved that Mr. Power found it more suitable for microscopical examination than many specimens of much more recent date. And this leads by a natural sequence to speak of John Hunter himself; Mr. Stephen Paget's recent life of that worthy being the text (3). This is the first of a series of biographies of *Masters of Medicine*, each by a different author. We welcome the series, since it helps to bring before the notice of the present upgrowing generation the pillars which have raised our profession to its present status.

In these days, when so much is known, there is of necessity much to learn before one reaches the "front" and can take one's place in the fighting line of advance. There is little time to consider the methods and temperaments of men who have added large links to the chain of knowledge which leads to our starting-point, and yet their lives are full of interest for us. It is therefore with much pleasure that one finds to one's hand the clear picture that Mr. Stephen Paget has drawn of John Hunter.

Not the least conspicuous merits of the book are its arrangement, the clear and pleasant style of its English, and the warmth and vitality that Mr. Paget has infused into his picture. To these the publishers have added good paper and a clear type, so that one feels that nothing has been omitted that could have added to the pleasure of reading the book. The value of the book is further enhanced by an introduction by Sir James Paget, and of this, having named the writer, there can be no more need of praise. We content ourselves with the statement that once having taken up the book few people will care to leave it so long as any part of it remains unread.

Mr. Paget concludes his preface with these words:—"The praise of John Hunter, and the long list of his achievements, are known to all of us; I have only tried to draw a plain sketch of him as he was seen by the men of his own days."

To these lines Mr. Paget has kept throughout, but the book is full of small details of Hunter's life which add a charm and reality to the story, and which would, many of them, have escaped a less sympathetic writer than Mr. Paget. They give an insight into the every-day life of John Hunter which without them would be impossible. One feels that one is at John Hunter's elbow, watching him work and hearing him lecture, and there is none of the heavy reading that one generally associates in one's mind with the word "biography."

The entry into surgical practice in London seems to have been little easier in Hunter's day than now. After he returned from the Peninsula at the age of thirty-five he "started practice in Golden Square. . . . First came the years of waiting for practice, that rise from the river of Time like the lean kine in Pharaoh's dream—'poor and ill-favoured and lean-fleshed, such as I never saw in all the land of Egypt for badness.' There were many difficulties in his way. He was only one more surgeon in London, against men of greater experience: and the good things of practice were in the hands of the leaders. . . . He had no hospital appointment; he had already lived twelve years in London, but in all that time had not published one word of writing: then for two more years he had disappeared out of England, his place in the school had been filled by Mr. Hewson, and things had gone on well without him. He had not the art of making patients; and his age was not altogether in his favour, for people would ask what he had been doing all this time."

To the people round Golden Square, Mr. Paget tells us, "John Hunter was known as a zealous student of the human body, who might or might not restore you to health, but would certainly wish to anatomise you if he failed."

Many of John Hunter's letters are reproduced, and those to Jenner in particular show well his keen, restless desire for facts—more facts,—however trifling their importance might seem, and the energy with which he pursued his quarry.

All these characteristics of John Hunter are brought out in the picturesque story that Mr. Paget tells, with the details of his youth, of his unhappy quarrel with William Hunter, of his tragic death at St. George's Hospital. These and many more make up a book full of interest, and one's only regret on reaching the end is that it is all too short. One has lived a little while with John Hunter, and

one seems to know something of his friends, his enemies, and his times, and much of himself and the way he worked and thought. And the time occupied in gaining this knowledge has been most pleasantly spent.

All who are interested in the history of medicine and surgery owe a debt of gratitude to Mr. Stephen Paget for his interesting *Life of Ambroise Paré* (4). It is impressed upon us at the outset that although Paré was a man who thought for himself in matters surgical, he was no rebel against authority like Paracelsus. His discovery that emollient dressings for wounds were preferable to the barbarous applications of boiling oil, resulted from a failure in the supply of oil on the battle-field, and no one was more fearful of the results of the experiment than Paré himself. His use of the ligature in amputation wounds was an application of the method already employed in wounds elsewhere.

The character of the man comes out clearly in Mr. Paget's pages. Energetic, fascinated with his profession, and delighting in his own skill, Ambroise Paré stands for all time an example of the practical man, testing all things, in conflict with the already musty tenets of the mediæval schoolmen. John Hunter himself was not a more ardent advocate for putting all to the test of experience; many are the points of resemblance to be traced between Mr. Paget's two heroes. His work was learnt in two stern and excellent schools—as resident surgeon to the Hotel Dieu at Paris for three years, and then on the field of battle. He shows, says the author, that "character in the long run avails more than circumstances. Ambroise Paré's methods are antiquated, his theories were all wrong, his books are the forgotten treasures of a few great libraries. Our methods, our explanations, will also be superseded; our books, many of them, will not even be treasured. He has kept his hold for three centuries upon men by force of character, and by that alone."

The workmanship of this book, which is dedicated to Sir Thomas Smith, is admirable. It is copiously illustrated with portraits, plans, figures of surgical instruments of the age, and many other matters to delight the heart of the antiquarian. Incidentally we learn many things of that time: that the conflict as to the respective provinces of physicians and surgeons was fought then even more fiercely than to-day; that the expression "feeding on ambrosia" was jocularly applied to Paré's methods of treatment, so careful was he of his patient's general condition; and lastly, that our hero was probably "ploughed" the first time he was examined for the diploma of Master Surgeon. Wherefore, O oft-rejected, take heart of grace!

Dr. Oswald Browne's thesis on *Aneurysms of the Aorta* (5) is a valuable piece of clinical work, embodying the observations on all the cases of this disease within the Hospital for the last thirty years. The course and termination usual in each situation is thoroughly discussed, but fanciful deductions and explanations are studiously avoided. To abstract his conclusions would be impossible in the space at our disposal, and we would refer all interested in the subject to this paper.

Dr. Hurry, of Reading, has a very practical scheme to advocate in his *District Nursing on a Provident Basis* (6). There is a large class of patients who cannot afford a private trained nurse, and who are quite above the need of charity. For such a plan is suggested by which trained nurses can be provided by a similar arrangement which obtains at present for dispensary medical attendance or sick clubs. We have often felt the need of some such scheme, and Dr. Hurry shows conclusively that it is not only possible but has in places been actually carried out.

Correspondence.

To the Editor of *St. Bartholomew's Hospital Journal*.

THE INDIAN MEDICAL SERVICE.

DEAR MR. EDITOR,—Last year when at Netley I promised a member of the JOURNAL committee that I would write an account of the life there. Unfortunately for my promise I was too much occupied that summer to finish my letter. However, I now venture to make amends for my remissness. Perhaps a few words about the Indian Medical Service may be of more interest to your readers. There are probably many good men at the Hospital passing their time as *locums* who have not made up their minds what to do ultimately. It is to them that this letter is addressed. I am not going to talk about the Army Medical Service. You all know that it is at present a most unpopular service, and its grievances are in every paper.

The Indian Medical Service is on quite a different footing, as over

half its members are in civil employ. The senior members in military employ sometimes feel the want of the proper recognition of their rank, but that will all come in time. The real disadvantages of the Indian Medical Service are those which it has in common with the Indian Civil Service, the Staff Corps, and, to some extent, all Indian Services;—insufficient leave, the great expense of double establishments if married, and the frequent separation from wife and children. Leave has now been closed to us for nine months. But if you do not marry you can avoid most of this, as you can afford short leave. What I want to point out is that if men do not much care for private practice, and can stand a hot climate, they had better try to enter the Indian Medical Service, for there is no comparison between the life of the average G. P. or his assistant and the life out here. Another point not shown in the papers supplied by the India Office concerns the amount of pay drawn in allowances. This must be qualified by drawing attention to the rule about passing the Lower Standard in Hindustani. No military allowance can be drawn until that decidedly stiff examination is passed. You may easily draw only Rs. 350 per month for a year, unless you have luck. Plague allowances are excepted. Personally I have drawn about Rs. 600 a month for the last nine months; of course, this is unusual luck in so young a member of the service. I leave your readers to work that out at 1s. 3½d., the exchange rate of the rupee to-day.

If you mean to come out, go up for the examination at once; the younger you are the better. Though, of course, good qualifications and good appointments help, it is not always these which tell for the best posts. Besides, if you wait you may become too old for promotion; whereas if you join young you may be able to come home later on and take your F.R.C.S. or M.D. It is not always pleasing to find a man who was your junior at hospital—perhaps one of your own dressers—senior to you in the service. There is every variety of opening out here for all tastes, and an energetic man is never at a loss. If you are a keen surgeon or specialist you are sure sooner or later to hit on a post where you can get all the material you want. The number of operations done by men out here puts even Bart.'s into the shade. Surely it is better to draw comfortable pay for a few years and do work that is not quite what you want in order to get posts like those in the Presidency towns and some of the native states, than to spend six to ten years in the dissecting room, perhaps to be passed over after all. As to general practice, in my opinion it is not to be compared with the Indian Medical Service.

To return to pay, you will probably find that after you pass the Lower Standard you will generally be drawing rather more than the pay of your rank *plus* the Rs. 100 for regimental allowance. In other words, this difficulty over, you generally get a little more than you have expected, as you obtain extra work. On the other hand, full charge appointments are slow in coming. In Madras at present you have to wait five years to get your regiment pukka. There is a good opening in Madras for specialists, as so many of the best men go to Bengal. And also every one in our service has military duty, whatever Presidency he comes from. However, if you are particularly keen on active service try for Bengal. Bombay has advantages too; it has more variety of climate than Madras in its military stations, and is nearer home.

If any one wants advice as to kit I shall be very glad to write to him. I got "let in" badly myself, and am in a position to talk on that subject. One good rule is to get the very least you can do with at Netley, and the rest out here. This is far cheaper, and some one on the spot will show you what you really want. You always stop long enough in Bombay to have a karkhee and white kit made for models, and after that the up-country dursee is cheaper, and can copy anything. Of course, if you are going to the frontier you may want a full kit from Bombay. Begin to learn Hindustani from the day you hear that you have passed, while you are yet young and energetic. I hope if any Bart.'s men are in the next batch to come out they will let me know, as I probably shall be in Bombay. Tell them to write care of W. Watson and Co., Bombay. I hear Stevenson is at the front in a field hospital. Walton is at Kalyan Junction in charge of the medical inspection of passengers. He just missed the Momand expedition, had a month's roughing it for nothing, and was then rushed back for plague work. That is the one thing you may count on here, general uncertainty as to where you will be to-morrow. So do not bring a wife with you when you come out. That must be left till later. I hope this long-winded prolix letter will bring me an answer from some one at Bart.'s,—there are one or two who owe me letters. Trusting part of this, at any rate, may interest some of your readers,

I am, sir, yours, &c.,

BOMBAY, Nov. 10th, 1897.

W. G. RICHARDS.

Appointments.

BROCK, J., M.R.C.S., L.R.C.P., appointed Assistant Medical Officer to the Uganda Railway.

DICKSON, A. W., M.R.C.S., L.R.C.P., appointed Assistant House Surgeon to the Royal Infirmary, Halifax.

GRANVILLE, A., M.R.C.S., L.R.C.P., appointed House Physician to the West London Hospital.

SHUTER, G. P., M.B., B.C. (Cantab.), D.P.H., appointed Anæsthetist to the West London Hospital.

Examinations.

UNIVERSITY OF CAMBRIDGE.—2ND M.B.—*Anatomy and Physiology*.—F. C. H. Home, N. MacLaren, J. C. Newman, G. H. Orton, J. S. Hamilton.

3RD M.B., Part i.—*Surgery and Midwifery*.—A. E. Carsberg, C. S. Myers, J. S. Sandilands. Part ii.—*Medicine*.—H. Boulton, W. L. H. Duckworth, J. G. Forbes, M. E. Hardy, A. E. Jeaffreson, T. H. Molesworth, C. S. Myers, H. D. O'Sullivan, S. Verdon-Roe, H. B. Shewell, R. A. Yeld.

LONDON UNIVERSITY.—M.D. EXAMINATION.—F. M. Burnett, R. H. Dickinson, W. d'Este Emery, S. Gillies, F. S. Locke.

B.S. EXAMINATION.—1st Division.—F. W. Robertson, E. J. Toye. 2nd Division.—J. E. G. Calverley, S. Cornish.

HONOURS LIST.—First Class.—E. J. Toye (qualified for Gold Medal).

M.B. HONOURS LIST.—*Medicine* 3rd Class.—F. W. Robertson, E. J. Toye. *Obstetric Medicine*.—1st Class.—E. J. Toye (Scholarship and Gold Medal); 2nd Class.—F. W. Robertson. *Forensic Medicine*.—2nd Class.—F. W. Robertson.

Births.

GARROD.—December 29th, at 9, Chandos Street, Cavendish Square, the wife of Archibald E. Garrod, M.D., of a son.

LAWRENCE.—December 25th, at 37, Belsize Avenue, N.W., the wife of Laurie A. Lawrence, F.R.C.S., of a son.

RICE.—December 1st, at 5, Clarence Terrace, Leamington, the wife of Bernard Rice, M.D. (Lond.), of a son.

STEEDMAN.—On November 30th, at High Road, Streatham, S.W., the wife of J. F. Steedman, F.R.C.S., of a son.

TUNNICLIFFE.—December 13th, at North Finchley, the wife of E. T. M. Tunnicliffe, of a son.

Marriage.

FORD—CRANE.—On December 28th, at St. John's, Notting Hill, by the Rev. Leonard Joyce, Frank Chubb Ford, M.B., of 47, Ladbroke Square, youngest son of the late Rev. John Chubb Ford, British Chaplain, Buenos Ayres, to Isabel Ellen, eldest daughter of the late Edward Crane, of Monte Video, and Mrs. Crane, of 14, Lansdowne Crescent.

ACKNOWLEDGMENTS.—*St. Mary's Hospital Gazette*, *The Student* (Christmas Number and McEwen Hall Special Number), *London Hospital Gazette*, *The Therapist*, *The Nursing Record*, *Guy's Hospital Gazette*, *The Guyoscope*, *Middlesex Hospital Journal*, *St. Thomas's Hospital Gazette*, *St. George's Hospital Gazette*, *The Sphygmograph*, *Giornale della Reale Societa Italiana d'Igiene*.